

72 07501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 07501

STATE OF MARYLAND-DEMD

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GELDOLF, MARY A. (COLLISON)

2. DATE AND HOUR OF DEATH

8/4/72 - 5:30 PM

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

117 S. Ann Street 21224

5. SEX

Female

6. RACE

Caucasian

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

4/9/94

9. AGE (in years
last birthday)

78

10. Under 1 Yr.

Months Days

11. Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

HOME

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

- Ruski

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

BCH Records 4940 Eastern Avenue 21224

ADDRESS

18. 4-36-71

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxiation, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

PNEUMONIA

(B)

DUE TO, OR AS A CONSEQUENCE OF:

CEREBROVASCULAR ACCIDENT

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

36 DAYS

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/1/72 19 to 8/4/1972
that (I) (we) last saw the deceased alive on 8/4/1972 and that (in my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Stanley Zoyac Jr., M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8/4/72

23C. PHYSICIAN'S
NAME (Type)

Stanley Zoyac Jr. M.D.

23D. ADDRESS

Baltimore City Hospitals Balto. Md. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

8-8-72

24C. NAME OF CEMETERY OR CREMATORY

ST. STANISLAUS Cem.

24D. LOCATION

BALTO. MD.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1972

25B. NAME OF REGISTRAR

Sidney H. Heston

25C. FUNERAL DIRECTOR

2334 Joffe St.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

()

87

X

A. Z. U

ANNALS

HOME

OFFICIAL

UNKNOWN

— RISKI

— No

8-8-55 25 STANISLAW (C) M. STANISLAW

Stanislaw - 9334

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07502 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 07502
STATE OF MARYLAND-DEMH

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) THERESA D BENSON

2. DATE AND HOUR OF DEATH 8/4-72 12:10 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOOD CONV. HOME
5313 EDMONDSON AVE.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTO
C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES ☒ NO ☐
E. STREET AND NUMBER 107 DELREY AVE

5. SEX F 6. RACE W 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH 8-7-88 9. AGE (In years last birthday) 83 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 11. BIRTHPLACE (State or foreign country) LONG ISLAND N.Y. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME DAYTON 14. MOTHER'S MAIDEN NAME UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. 217 48 9548 17. INFORMANT KENNETH F. BENSON ADDRESS 107 DELREY AVE

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Cardiac Arrest

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
ASCVD

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
II

19A. DATE OF OPERATION 8/3/72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) NO 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR? NO

22. I certify that (I) (this hospital) attended the deceased from 8/3 1972 to 8/4 1972 that (I) (we) last saw the deceased alive on 8/3 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

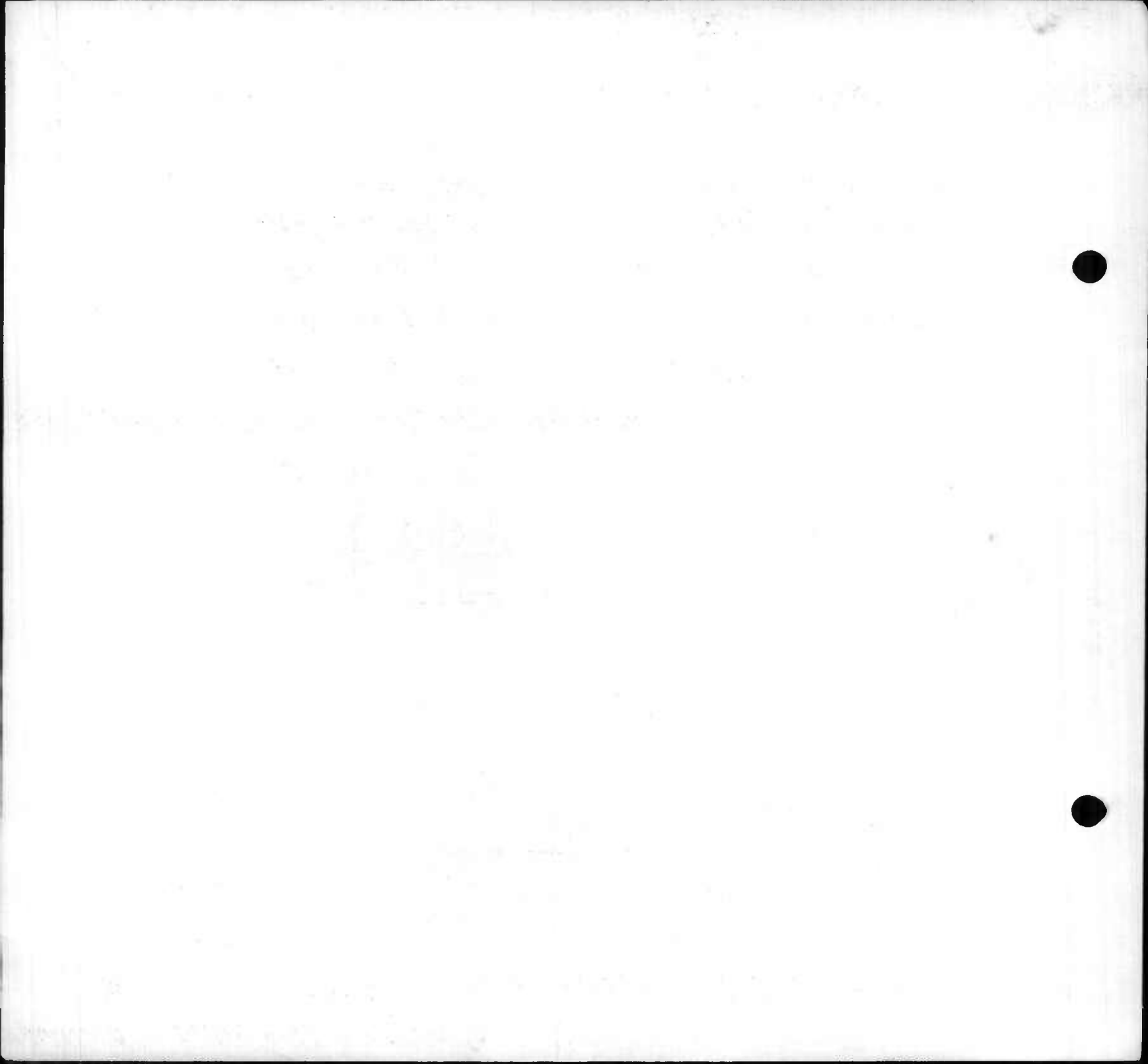
23A. SIGNATURE James Nolan 23B. DATE SIGNED 8/4/72
Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23C. PHYSICIAN'S NAME (Type) JJ NOLAN 23D. ADDRESS Baltimore Md 21229

24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 8-7-72 24C. NAME of CEMETERY or CREMATORY LORRAINE PARK 24D. LOCATION (City, town, or county) (State) WOODLAWN MD.

25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972 25B. NAME OF REGISTRAR Delaney 25C. FUNERAL DIRECTOR WEBER ADDRESS FUNERAL HOME 5311 EDMONDSON AVE

VS 150-REV. 1/1/76



FUNERAL DIRECTOR: IMPORTANT

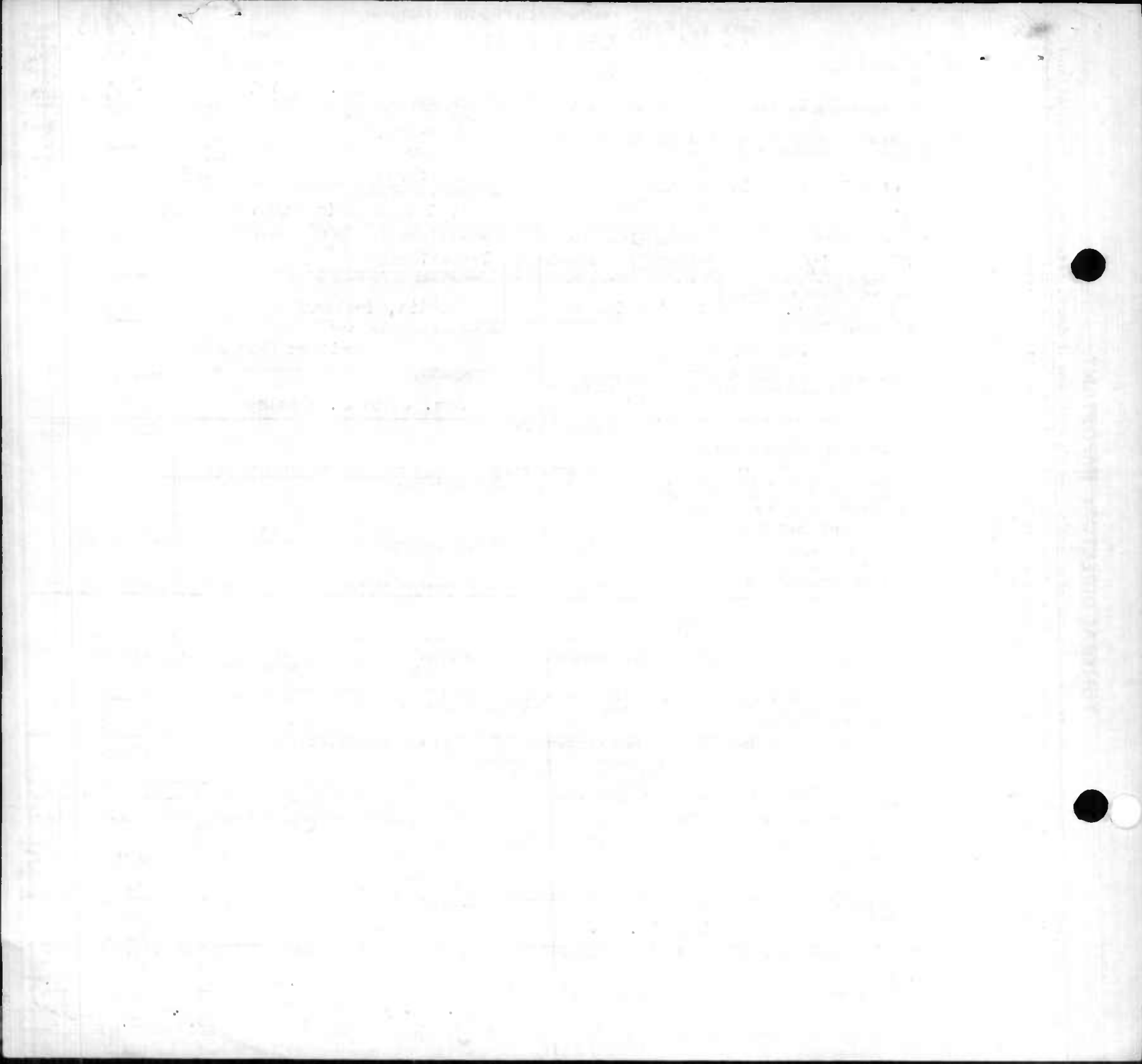
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07503

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO. 72 07503

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND-DHMH	
		Anastasia Marie Feeley		Aug. 6, 1972		9 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 767 McKewin Avenue				A. STATE Maryland			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 767 McKewin Avenue		21218	
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-24-1894	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Matron Dept. of Motor Vehicles				11. BIRTHPLACE (State or foreign country) Dublin, Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph O'Toole				14. MOTHER'S MAIDEN NAME Bridget Donnelly			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-36-1980		17. INFORMANT Mr. John J. Feeley		ADDRESS Same	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Artery Heart Dis		10 years	
				(B) Chronic Ulcerative Colitis		5 years	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 1940 to 8/6 1972 that (1) (we) lost saw the deceased alive on 8/5 1972 and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sol Smith				23B. DATE SIGNED 8/6/72			
23C. PHYSICIAN'S NAME (Type) Sol Smith M. D.				23D. ADDRESS 6810 Park Hts Ave Balto Md 21215			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-9-72		24C. NAME of CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1972		25B. NAME OF REGISTRAR S. J. Jenkins		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4995 York Road Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07504

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 72 07504

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

DR. DONALD G. ALLEN

2. DATE AND HOUR OF DEATH

8/4/72

15:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1109 Harriton Road

5. SEX

Male

6. RACE

Cauc.

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

12/05/03

9. AGE (In years last birthday)

68

11. Under 1 Yr. Months Days

12. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Professor

10B. KIND OF BUSINESS OR INDUSTRY

Teaching

11. BIRTHPLACE (State or foreign country)

Missouri

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alvin Allen

14. MOTHER'S MAIDEN NAME

Anna Weinmann

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

220-30-4190A

17. INFORMANT

Mrs. Mary C. Allen

ADDRESS

1109 Harriton Rd.

21210

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

ADENOCARCINOMA OF LUNG

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 YEARS

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

No

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/3 1972 to 8/4 1972 that (I) (we) last saw the deceased alive on 8/4 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

James K. Brown M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

8/4/72

23C. PHYSICIAN'S NAME (Type)

James K. Brown, M.D.

23D. ADDRESS

The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

8-4-72

24C. NAME of CEMETERY or CREMATORY

Loudon Park Crem.

24D. LOCATION

Balto.

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

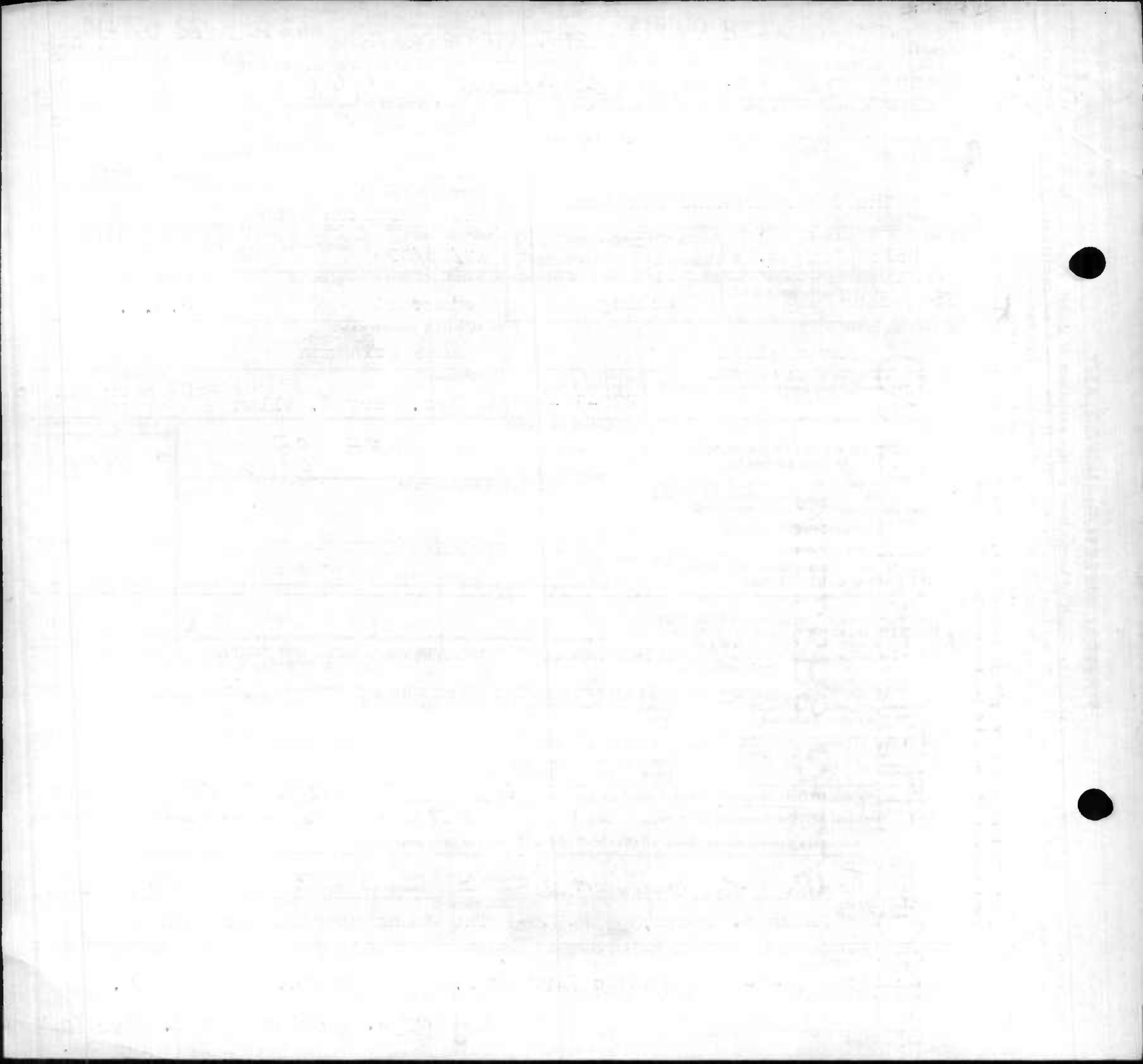
AUG 7 1972

25B. NAME OF REGISTRAR

Lidnykh

25C. FUNERAL DIRECTOR

Henry W. Jenkins & Sons, 4905 York Rd.



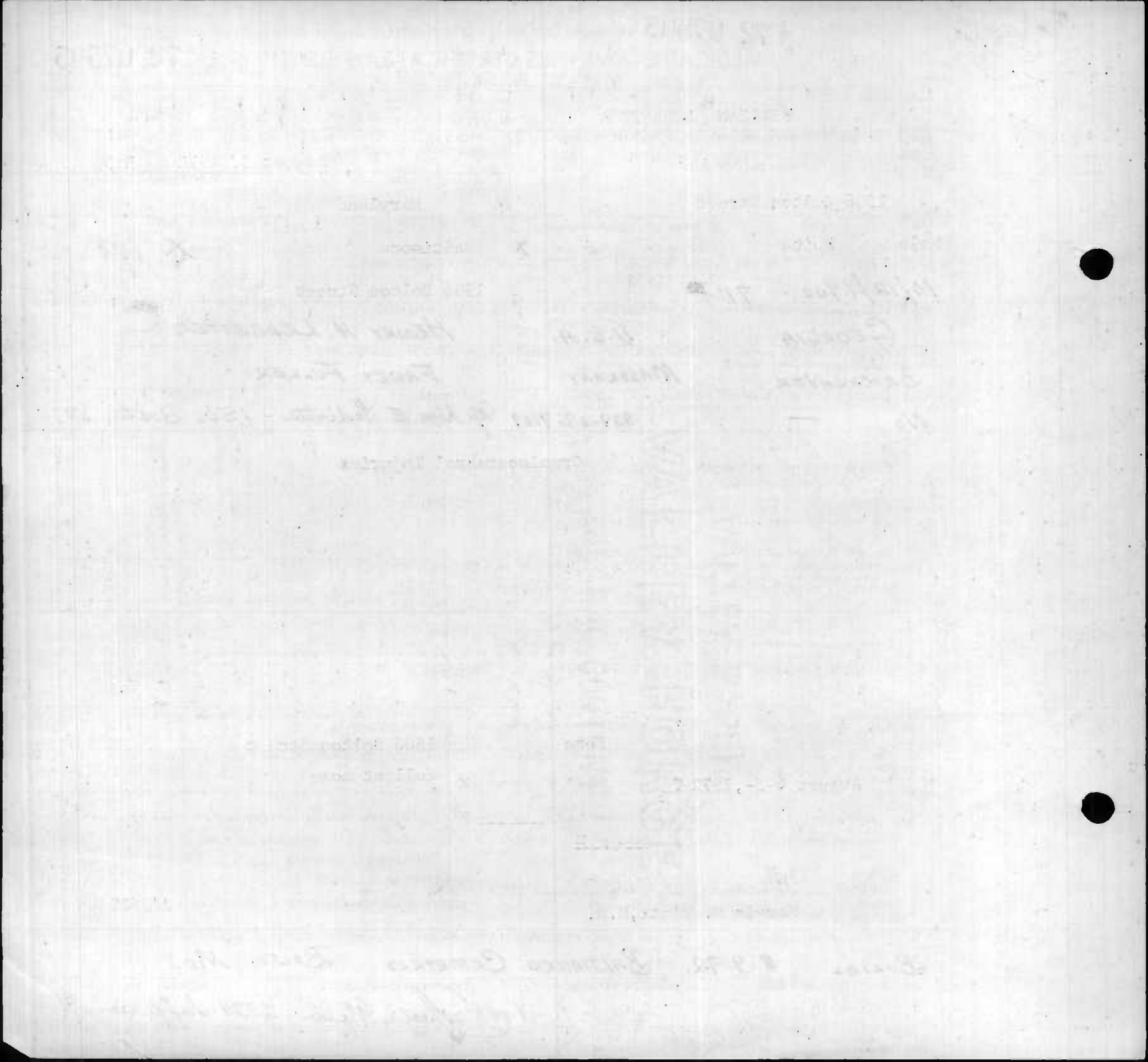
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07505

BIRTH NO.

STATE OF MARYLAND-DEMH

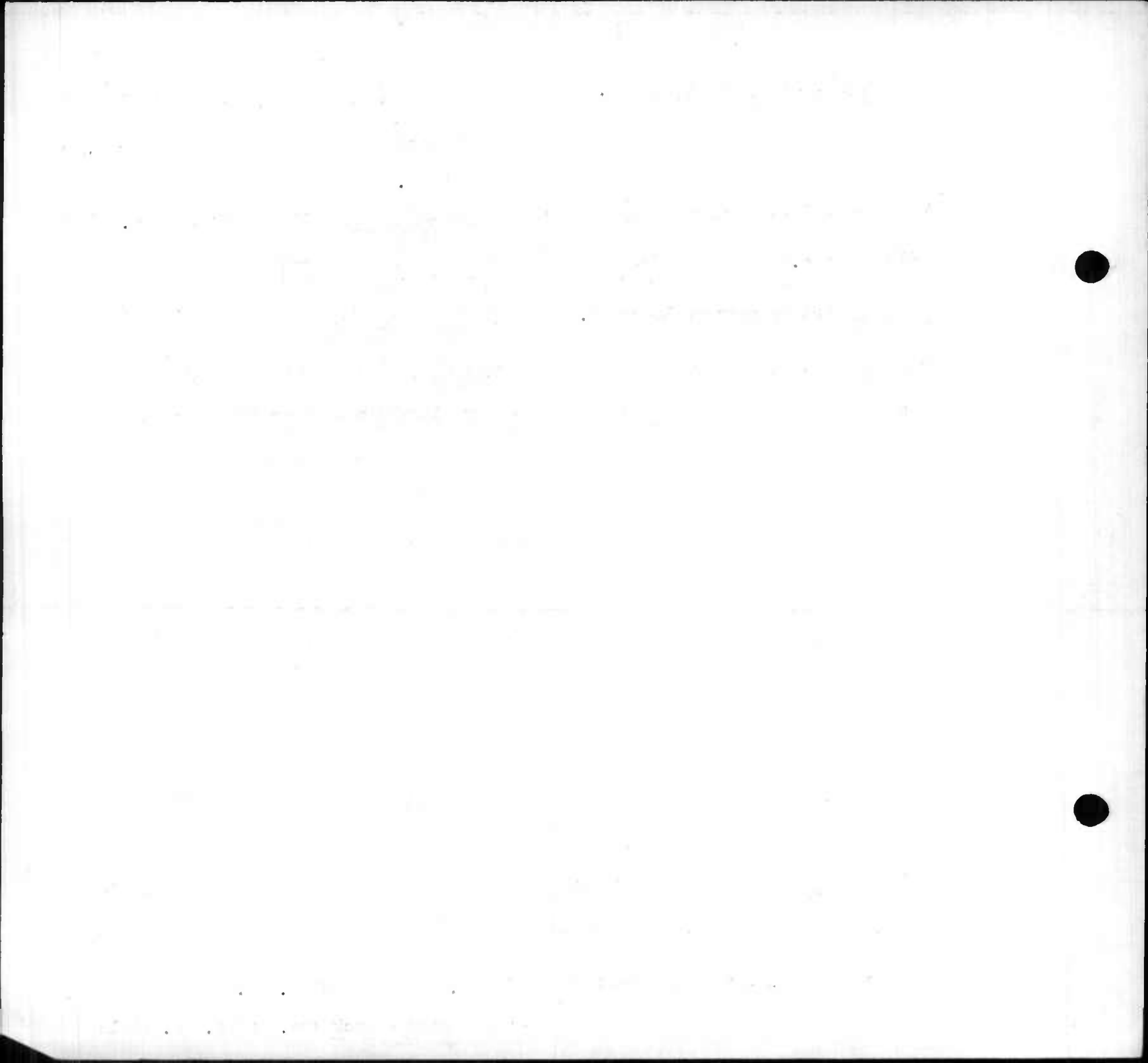
1. NAME OF DECEASED (Type or Print) WILLIAM H. LEDBETTER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1506 Bolton Street		3. DATE PRONOUNCED DEAD Month Day Year Hour August 5, 1972 3:34 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10/12/1900		10. AGE (In years last birthday) 71	
11. BIRTHPLACE (State or foreign country) GEORGIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICKLAYER		14B. KIND OF BUSINESS OR INDUSTRY MASONARY	
15. MOTHER'S MAIDEN NAME FANEY FULLER		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 239-07-9109		18. INFORMANT ADDRESS Mr. Hm. E. Ledbetter - 1506 Bolton St.	
19. CAUSE OF DEATH Craniocerebral Injuries		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1506 Bolton Street		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) August 4-5-, 1972 ? m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? fell at home	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Marvin S. Platt		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Marvin S. Platt, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 8/5/72			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-9-72	
24C. NAME of CEMETERY or CREMATORY BALTIMORE CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1972		25B. NAME OF REGISTRAR Sidney W. Weston	
25C. FUNERAL DIRECTOR Southgate		ADDRESS 2334 Jefferson St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 07506		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 07506	
1. NAME OF DECEASED (Type or Print) <u>Trimble, Anna E.</u>		2. DATE AND HOUR OF DEATH <u>Aug 5, 1972</u> <u>15³⁰</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Keswick - Home for Incurables</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3219 Woodhome Ave.</u> <u>21234</u>			
5. SEX <u>Female</u>	6. RACE <u>Cauc W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/30/1890</u>	9. AGE (in years last birthday) <u>81</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> <u>Shirt Presser</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Marlboro Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>George W. Hoffman</u>		14. MOTHER'S MAIDEN NAME <u>Anna Elizabeth Engelhart</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-01-2814</u>		17. INFORMANT <u>Mrs Elizabeth Stuller</u> <u>3219 Woodhome Ave</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute cerebrovascular hemorrhage</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral arteriosclerosis (previous multiple small CVA's)</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Diabetes mellitus</u>		(B) <u>multiple small CVA's</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes mellitus</u>		<u>7 years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Diabetes mellitus</u>				<u>11 years</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that he (this hospital) attended the deceased from <u>2/10/69</u> 19 to <u>8/5/72</u> 19 that he (we) last saw the deceased alive on <u>8/5/72</u> 19 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.					
23A. SIGNATURE <u>W.B. Daniels, Jr.</u> <u>M.D.</u>		23B. DATE SIGNED <u>8/5/72</u>		23C. PHYSICIAN'S NAME (Type) <u>W.B. Daniels, Jr.</u> <u>M.D.</u>	
23D. ADDRESS <u>Keswick, 700 W. 40th St.</u> <u>Baltimore</u> <u>21211</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>8-8-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1972</u>		25B. NAME OF REGISTRAR <u>Ordway Houston</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u> <u>Balto. Md. 21214</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

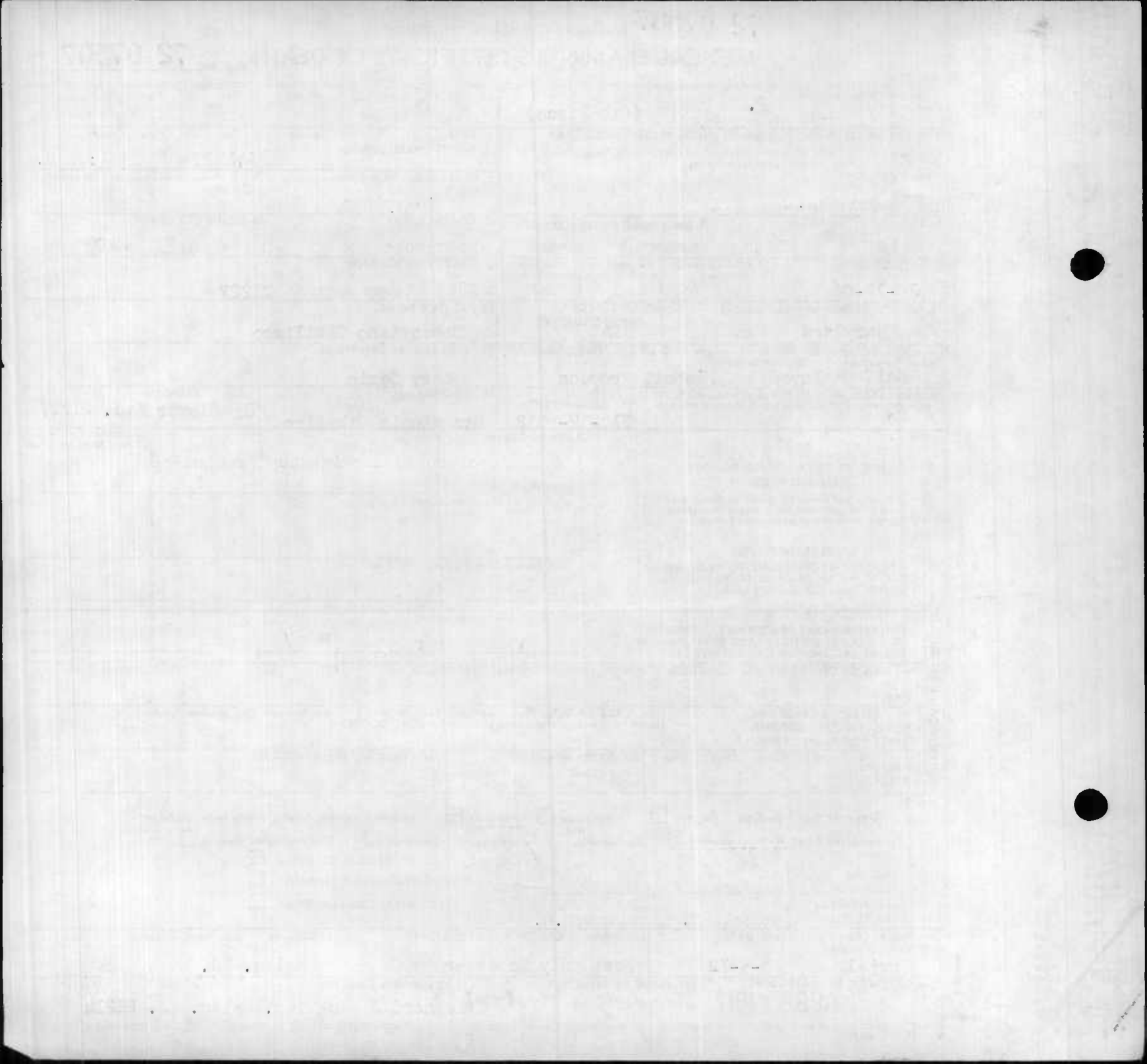
STATE OF MARYLAND-DHMH

REG. NO.

72 07507

BIRTH NO.

1. NAME OF DECEASED (Type or Print) P. JOSEPH GIBILINO (Gibilisco)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year August 4, 1972 Hour 4:50 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10-12-06		10. AGE (in years lost birthday) 65	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		14B. KIND OF BUSINESS OR INDUSTRY Retail Produce	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 216-12-9072	
18. INFORMANT Mrs Minnie Gibilino		ADDRESS 3515 Clover Ave. 21227	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. EXAMINER'S NAME (Type)		DATE SIGNED 8/5/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-9-72	
24C. NAME of CEMETERY or CREMATORY Most Holy Redeemer		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1972		25B. NAME OF REGISTRAR Andrew Johnston	
25C. FUNERAL DIRECTOR Leonard J Ruck Inc. Balto. Md. 21214		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 07508

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

AUGUST O. GIESIN

2. DATE AND HOUR OF DEATH

Aug 7 1972 1:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

90 Edgewood Nursing Home

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE B. COUNTY

Maryland

BALTO

5300

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

25 Birdsnest Court 21227

5. SEX

Male

6. RACE

Cauc.

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

10-18-11

9. AGE (In years
last birthday)

60

If Under 1 Yr.
Months Days

If Under 24 Hrs.
Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Tool & Die Maker

10B. KIND OF BUSINESS OR INDUSTRY

Eastern Product Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

August O Giesin

14. MOTHER'S MAIDEN NAME

Gertrude Spielman

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-05-2570HA

17. INFORMANT

ADDRESS

Milton Giesin 807 Winans Way 21229

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Glomerular Nephritis

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

10 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

12-9-71

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Left frontal lobectomy

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb 1 1972 to Aug 7 1972
that (I) (we) lost saw the deceased alive on Aug 6 1972 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Frederick J. Vollmer MD

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

Aug 7, 1972

23C. PHYSICIAN'S
NAME (Type)

FREDERICK J. VOLLMER MD

23D. ADDRESS

6100 YORK RD BALTIMORE MD

24A. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-9-72

24C. NAME of CEMETERY or CREMATORY

Parkwood Cem.

24D. LOCATION

Balto.

(City, town, or county)

Balto.

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

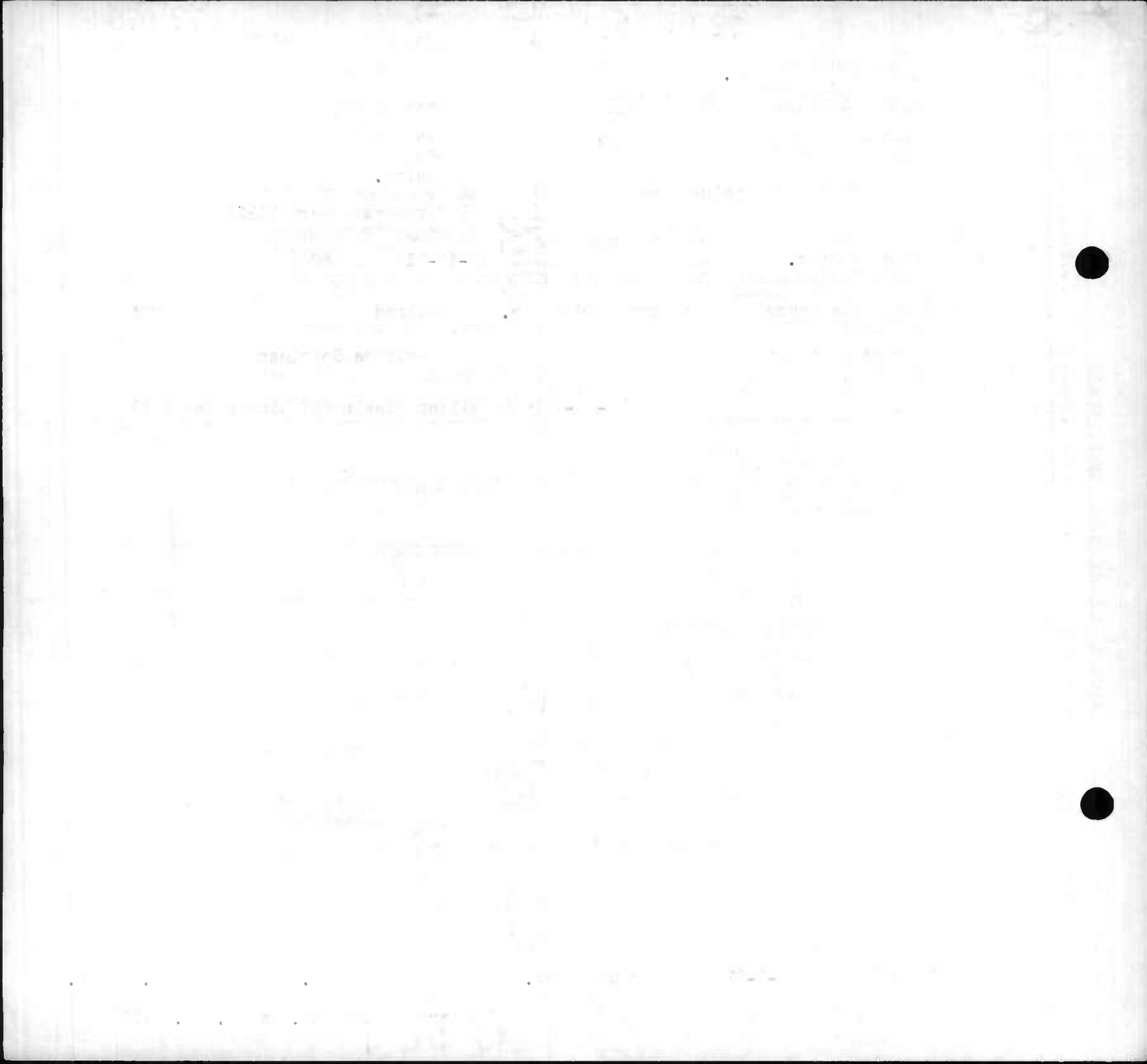
AUG 8 1972

25B. NAME OF REGISTRAR

Anthony J. [Signature]

25C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto. Md. 21214



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 07509</u>
72 07509 CERTIFICATE OF DEATH				STATE OF MARYLAND-DHMH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>THOMSON KING</u>		
2. DATE AND HOUR OF DEATH <u>8-1-72</u> <u>2:05 P.</u> M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u>		
4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1307</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-7-85</u> 9. AGE (In years last birthday) <u>86</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>Harwood, Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>		13. FATHER'S NAME <u>THOMSON M. KING</u>		
14. MOTHER'S MAIDEN NAME <u>MARY E. THOMPSON</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>212 05 6565A</u>		17. INFORMANT ADDRESS <u>Katharine Naylor, Baltimore, Md</u>		
18. <u>560.1</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs.</u>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>LARGE BOWEL OBSTRUCTION</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>FECAL IMPACTION.</u> (B) DUE TO, OR AS A CONSEQUENCE OF:				
(C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>PNEUMONIA.</u>				
19A. DATE OF OPERATION <u>N.A.</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N.A.</u>		20A. AUTOPSY? (Yes or No) <u>1</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <u>N.A.</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>N.A.</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>N.A.</u>
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>N.A.</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>N.A.</u>
22. I certify that (I) (this hospital) attended the deceased from <u>8-1-72</u> 19 <u>72</u> to <u>8-1</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>8-1</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Tadashi Kuba</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>Tadashi Kuba</u>
23D. ADDRESS <u>THE UNION MEMORIAL HOSP. 33rd and CALVERT ST. BALTIMORE, MD</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-4-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Christ Church</u>
24D. LOCATION (City, town, or county) (State) <u>Owensville, Md AACo</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1972</u>		25B. NAME OF REGISTRAR <u>Andrew Houston</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Hardesty Funeral Home, Annapolis, Md</u>

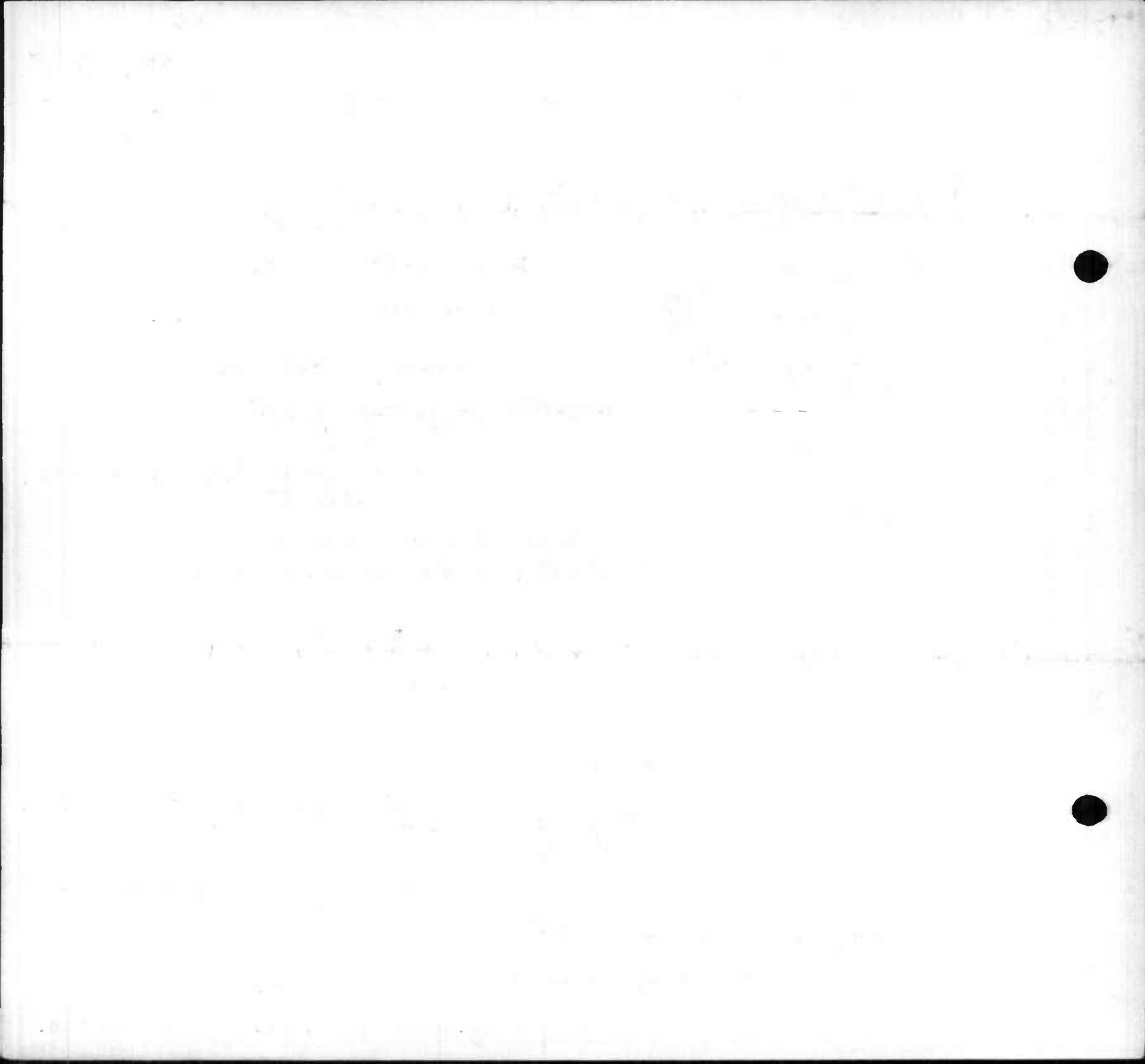
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

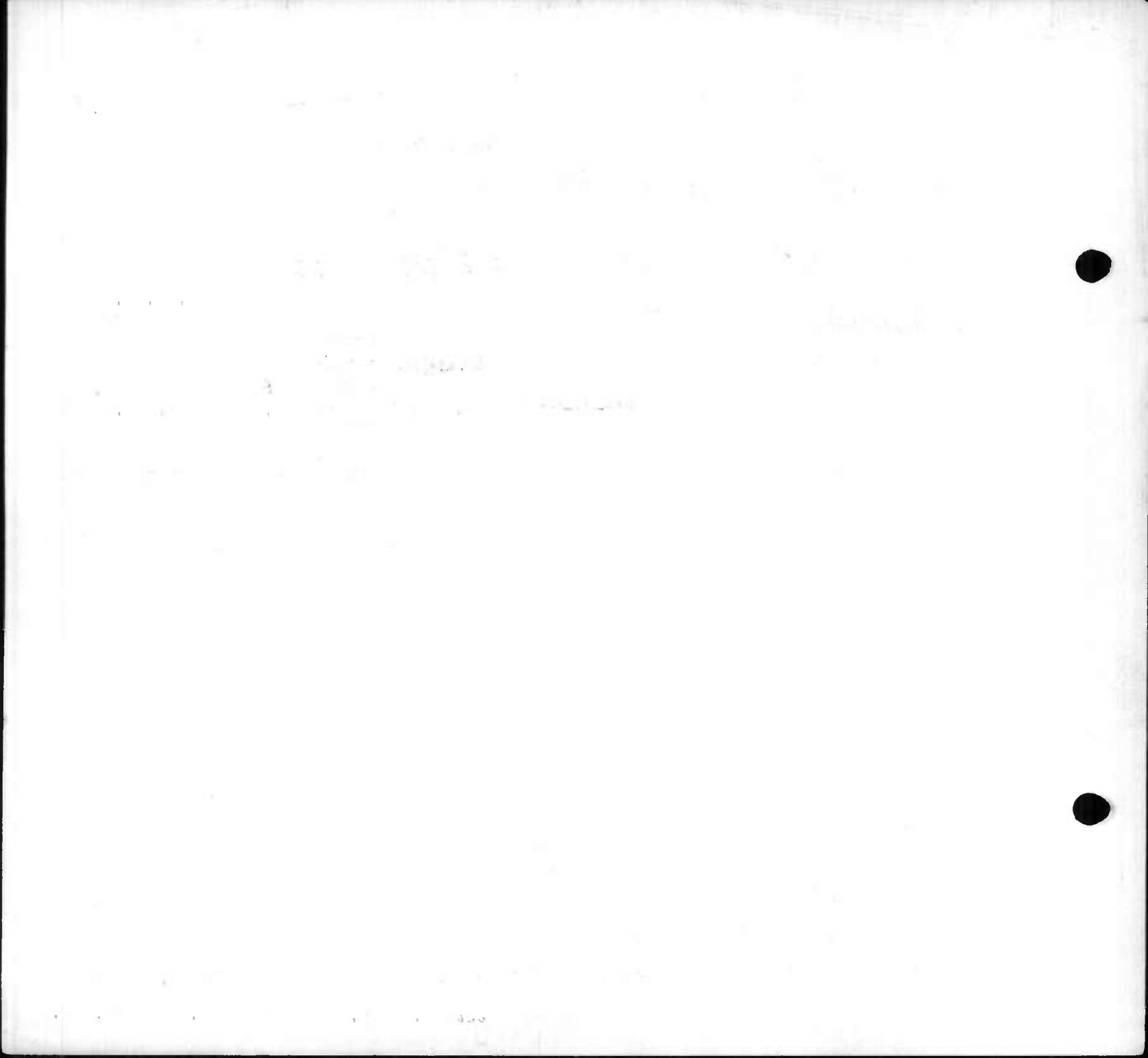
72 07510 BALTIMORE CITY HEALTH DEPARTMENT		72 07510	
CERTIFICATE OF DEATH		REG. NO. STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <u>Virginia Hazelwood</u>		2. DATE AND HOUR OF DEATH <u>August 3, 1972</u> <u>10 18</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION: <u>Montebello State Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE: <u>Md.</u> B. COUNTY: <u>1338</u>	
5. SEX: <u>F</u>		6. RACE: <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH: <u>10-06-00</u>		9. AGE (In years last birthday): <u>71</u>	10. Under 1 Yr. Months: <u>71</u> Days: <u>71</u> Hours: <u>71</u> Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>HARVEY GRIM</u>		14. MOTHER'S MAIDEN NAME: <u>Minnie Ashwood</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO.: <u>213-03-7574</u>	
17. INFORMANT: <u>Hospital Chart</u>		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>3-4 mos.</u>	
(A) IMMEDIATE CAUSE: <u>Cerebro-vascular</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Accident</u>			
(B) <u>Hypertensive arterio-</u> DUE TO, OR AS A CONSEQUENCE OF: <u>sclerotic Cardio-vascular disease</u>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION: <u>8-7-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.): (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED: White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>July 20</u> 19 <u>72</u> to <u>Aug. 3</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Aug. 3</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE: <u>CORAZON CUEVAS, M.D.</u>		23B. DATE SIGNED: <u>8-3-72</u>	
23C. PHYSICIAN'S NAME (Type): <u>CORAZON CUEVAS, M.D.</u>		23D. ADDRESS: <u>Druid Ridge Cemetery</u>	
24A. BURIAL CREMATION, REMOVAL (Specify): <u>Burial</u>		24B. DATE: <u>8/7/72</u>	
24C. NAME OF CEMETERY or CREMATORY: <u>Druid Ridge Cemetery</u>		24D. LOCATION: <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT.: <u>AUG 8 1972</u>		25B. NAME OF REGISTRAR: <u>Anthony Schostone</u>	
25C. FUNERAL DIRECTOR: <u>Alan Seitz, Jr.</u>		ADDRESS: <u>3818 Roland Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07511		REG. NO. 72 07511	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Roberta Irene Dickerson				2. DATE AND HOUR OF DEATH 8/2/72 17:10 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Maryland Hospital University of Maryland				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Sparrows Point D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1019 H Street			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/09		9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY School Teacher		11. BIRTHPLACE (State or foreign country) Maryland Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A. A. S. A.	
13. FATHER'S NAME James Watson				14. MOTHER'S MAIDEN NAME Laura Donaldson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-22-8350		17. INFORMANT (Daughter) 6913 Belclare Rd. Mrs. Patricia Woodham, Dundalk, Md. 21222			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Spasms from urinary tract inf. Brain Cardiac Arrhythmia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks immediate	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (A) (this hospital) attended the deceased from 5/23/72 to 8/2/72 that (B) (we) last saw the deceased alive on 8/2/72 and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Richard A. Tomasulo M.D.				23B. DATE SIGNED 8/2/72			
23C. PHYSICIAN'S NAME (Type) Richard A. Tomasulo				23D. ADDRESS Univ. of Md. Hosp			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 8/5/72		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1972		25B. NAME OF REGISTRAR Lidney Whitton		25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07512

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07512

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH S. CASCIO

2. DATE AND HOUR OF DEATH

August 4, 1972

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2643 Dulany Street
Baltimore, Maryland 21223

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN
Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2643 Dulany Street

5. SEX

Male

6. RACE

White

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

2 AUG 1896

9. AGE (In years
last birthday)

76

If Under 1 Yr.

Months

Days

Hours

If Under 24 Hrs.
Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Barber

10B. KIND OF BUSINESS OR INDUSTRY

Barber

11. BIRTHPLACE (State or foreign country)

New Orleans, Louisiana

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Vincent Cascio

14. MOTHER'S MAIDEN NAME

~~REYNOLDS~~ Sarah Rinauldo

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)
No

16. SOCIAL
SECURITY NO.

219-32-0564

17. INFORMANT

ADDRESS

Mrs. Elizabeth Cascio, 2643 Dulany St. 21223

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Cerebral Arteriosclerosis

9 months

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerosis, generalized

10 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

none

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1957 to 1972 date 1972
that (I) (we) last saw the deceased alive on 28 July 1972 and that in (my) ~~last~~ opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) ~~(not)~~ view the body after death.

23A. SIGNATURE

Conrad Acton

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

4 Aug 72

23C. PHYSICIAN'S
NAME (Type)

Conrad Acton

23D. ADDRESS

2 E. Read Street, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-8-1972

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 8 1972

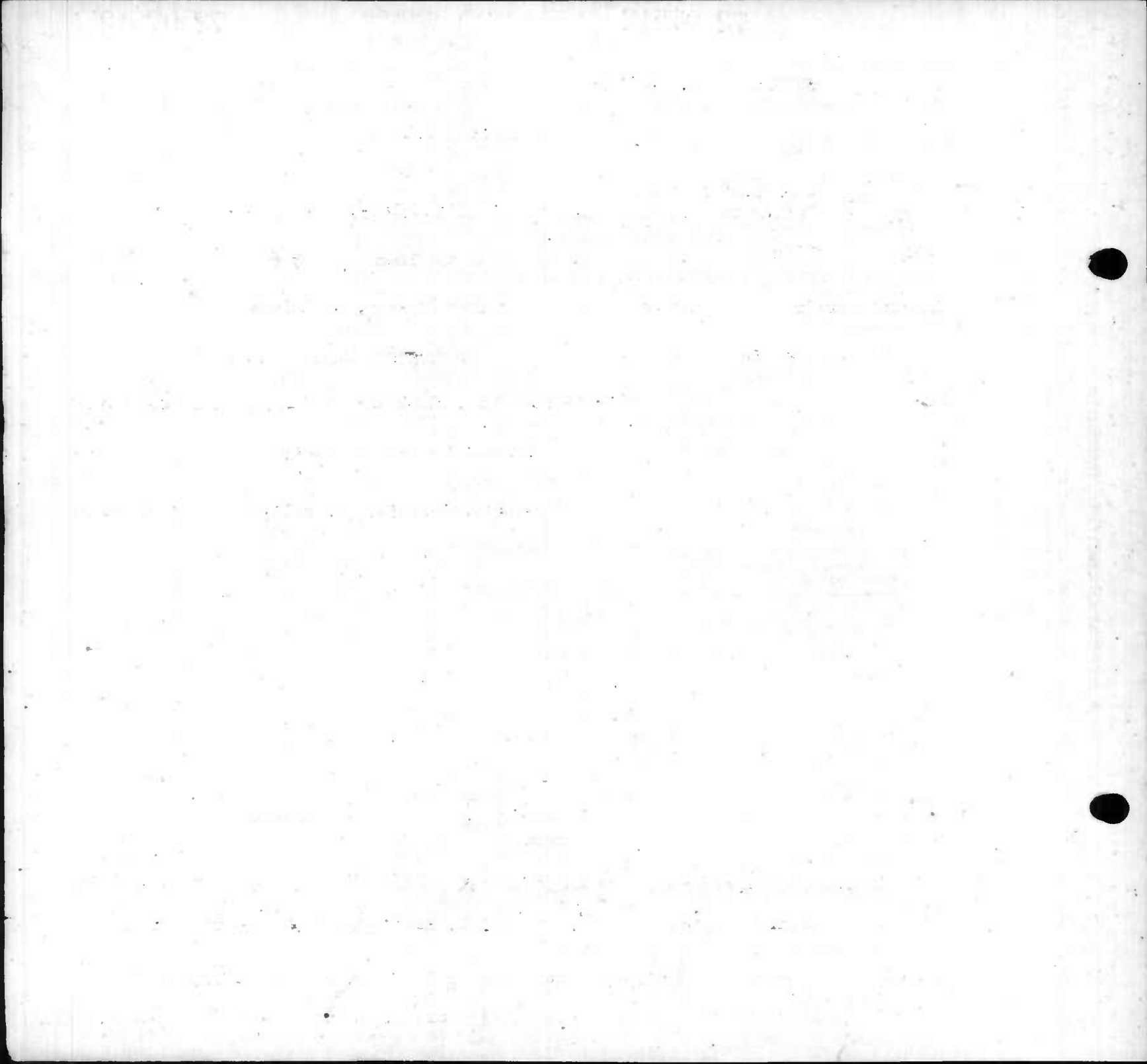
25B. NAME OF REGISTRAR

Sidney H. Hubbard

25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave. 21229

ADDRESS



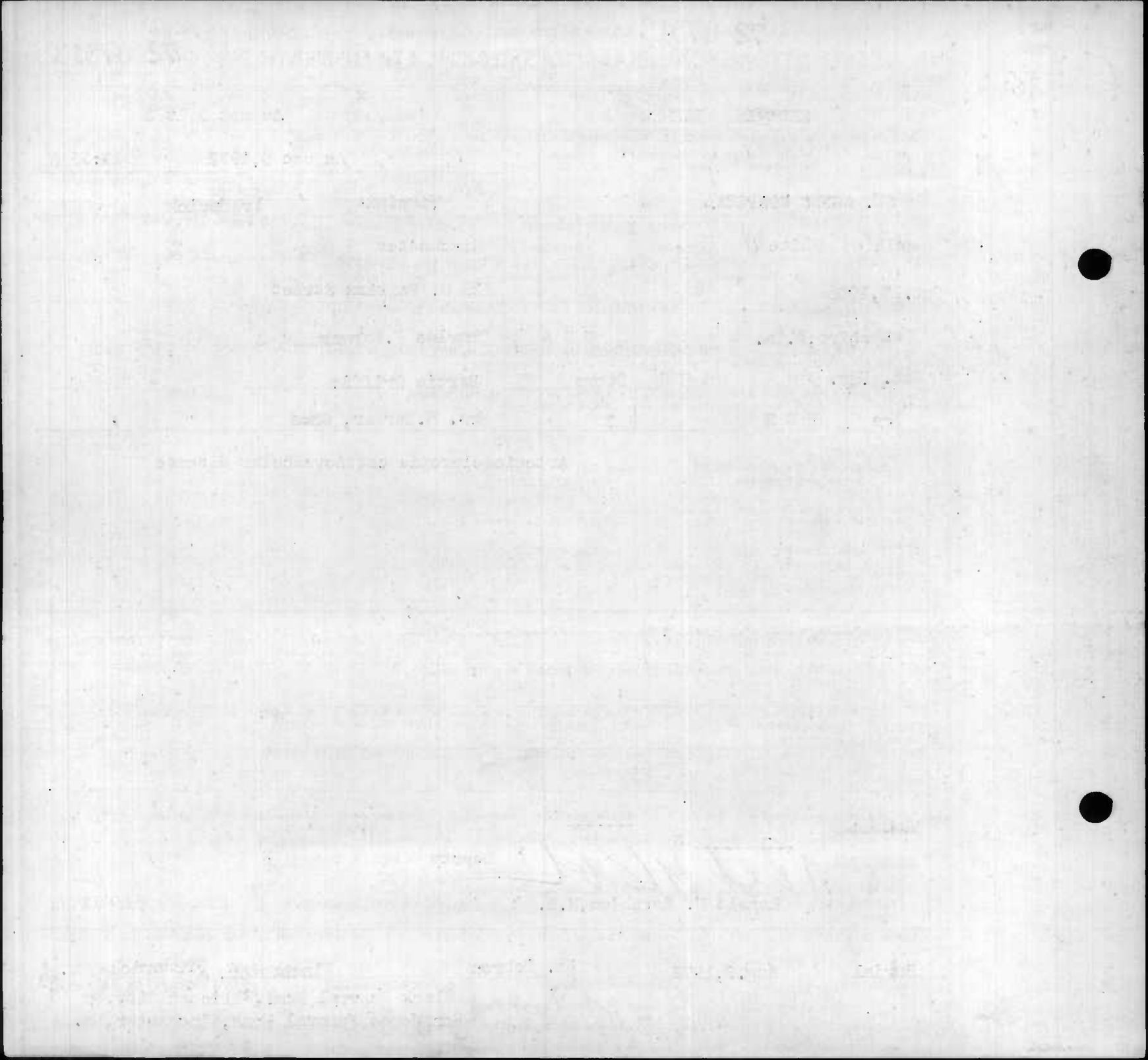
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07513

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) SHERWIN FARMER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour August 5, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour August 5, 1972 12:55 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Winchester	
9. DATE OF BIRTH Oct. 27, 1906		10. AGE (In years last birthday) 65	
11. BIRTHPLACE (State or foreign country) Hampshire, W. Va.		12. CITIZEN OF WHAT COUNTRY? U S A	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Mgr.		14B. KIND OF BUSINESS OR INDUSTRY A B C Store	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W 2		17. SOCIAL SECURITY NO. ?	
15. MOTHER'S MAIDEN NAME Bertie Griffin		18. INFORMANT ADDRESS Mrs. S. Farmer, Same	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type): Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 8/5/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 8, 1972	
24C. NAME of CEMETERY or CREMATORY Mt. Hebron		24D. LOCATION (City, town, or county) (State) Winchester, Frederick, Va.	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1972		25B. NAME OF REGISTRAR Sidney H. Hooton	
25C. FUNERAL DIRECTOR Slack Funeral Home, Ellicott City, Md.		25D. ADDRESS Slack Funeral Home, Winchester, Va.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07514

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07514

STATE OF MARYLAND-DEMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)Anna M. Kaczynski
ANNA KACZYNSKI

2. DATE AND HOUR OF DEATH

7/31/72

10:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTIONIF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue Baltimore, Maryland
212244. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Md. B. COUNTY

MARYLAND Baltimore

C. CITY OR TOWN Dundalk

D. INSIDE CITY LIMITS?

YES ☒NO ☒

E. STREET AND NUMBER 1419 Dundalk Avenue

1419 DUNDALK AVE

5. SEX

Female

6. RACE

Caucasian

7. MARRIED

NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

9/15/18

9. AGE (in years
last birthday)

53

11 Under 1 Yr.
Months Days11 Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Derus

14. MOTHER'S MAIDEN NAME

Maryanna ?

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-03-6779

17. INFORMANT

4940 Eastern Avenue ADDRESS

BCH: RECORDS Baltimore, Maryland 21224

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiac Arrest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

30 minutes

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Acidosis + Anterolateral MI

Unknown

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Diabetes mellitus

Unknown

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/31/72 to 7/31/72
that (I) (we) last saw the deceased alive on 7/31/72 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Linda Kay Markley, M.D.

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

7/31/72

23C. PHYSICIAN'S
NAME (Type)

LINDA KAY MARKLEY M.D.

23D. ADDRESS

5964 East Pratt St
Baltimore City Hospitals
4940 Eastern Avenue 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-3-72

24C. NAME of CEMETERY or CREMATORY

St. Stanislaus Cemetery

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 8 1972

25B. NAME OF REGISTRAR

Sidney J. Duda

25C. FUNERAL DIRECTOR

John J. Duda 2829 Hudson St. Balto. Md. 21224

ADDRESS

1
S-163

72 07515 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

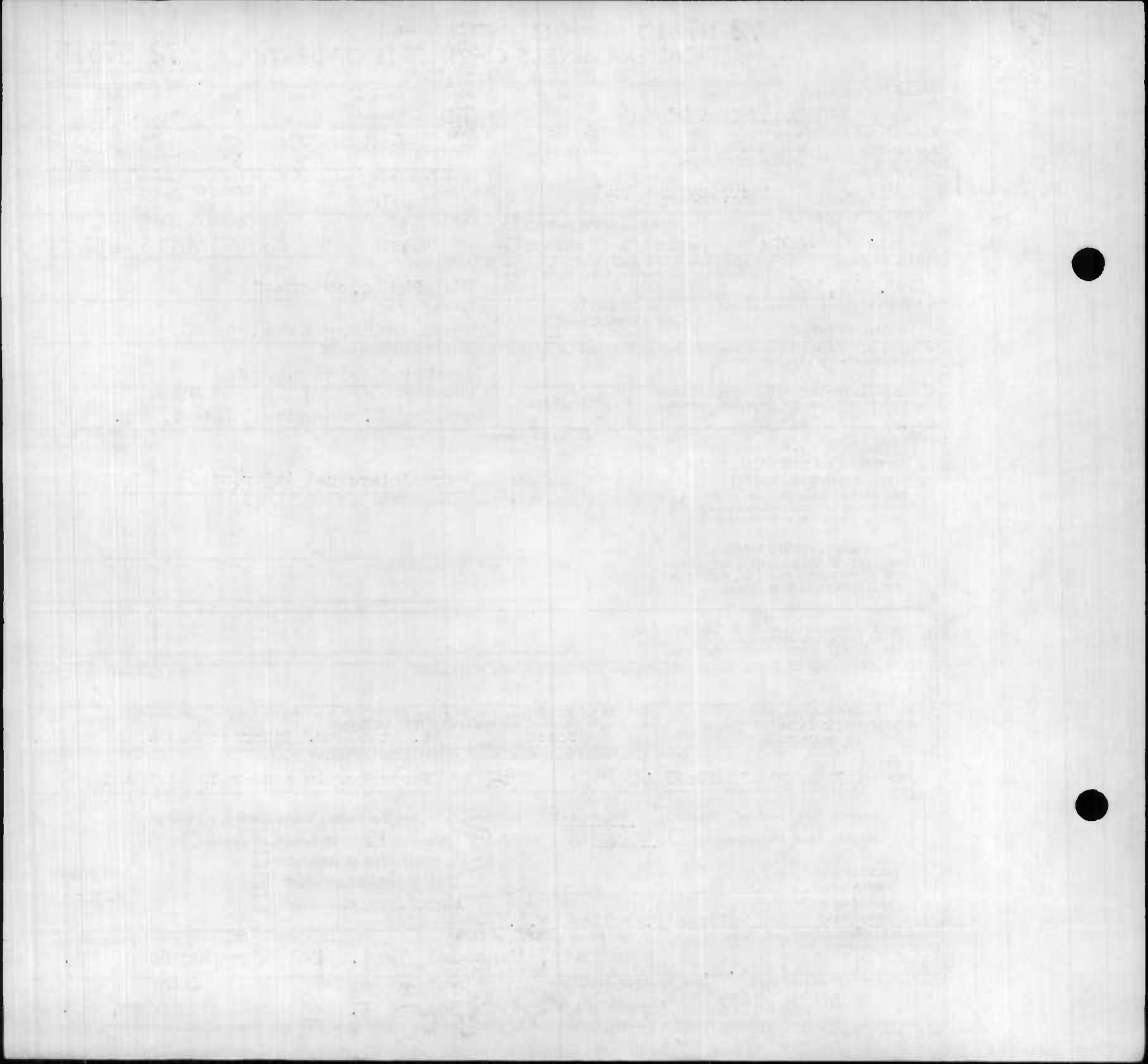
72 07515

BIRTH NO. 69-21121

STATE OF MARYLAND-DHMH

REG. NO.

1. NAME OF DECEASED (Type or Print) DEENA LYNN SHEPARD		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 8 4 72 Hour: 12:00 Noon M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year 8 4 72 Hour: 12:00 Noon M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Harford	
9. DATE OF BIRTH Nov. 13, 1969		10. AGE (In years last birthday) 2 If Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank Anthony Catalano		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
15. MOTHER'S MAIDEN NAME Dorothy Louise Shepard		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE	
17. SOCIAL SECURITY NO. NONE		18. INFORMANT ADDRESS Dorothy L. Shepard Joppa, Md.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) St. Rt #7 nr. Intersection of Joppa Rd.		22D. TIME OF INJURY (APPROX.) 7 30 72 10:35 P.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Passenger in auto-auto accident	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>W P Mulloy</i> M.D. EXAMINER'S NAME (Type) William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 7, 1972	
24C. NAME OF CEMETERY or CREMATORY Bel Air, Memorial Gard.		24D. LOCATION (City, town, or county) (State) Bel Air Harford Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1972		25B. NAME OF REGISTRAR <i>Andrew W. Boston</i>	
25C. FUNERAL DIRECTOR Howard K. McComas		ADDRESS Abingdon, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07516		REG. NO. 72 07516		STATE OF MARYLAND-DHMH	
BIRTH NO.				CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
Ruth Purcell				7/28/72		9:18 p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY			
SOUTH BALTIMORE GENERAL HOSPITAL 3001 S. Hanover Street				Maryland					
5. SEX				6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Mar. 6, 1913		9. AGE (In years last birthday) 59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife						Delta, Pa.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
John N. Parthreese				Cecelia Dawney					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No						Mrs. Jerry Coke, Whiteford, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES				DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						No.			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/28/72 7/28/72 to 7/28/72 19 70 to 7/28/72 19 that (I) (we) last saw the deceased alive on 7/28/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
E. H. Weiss - M.D.				7-29-72					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
				615 Hammonds Lane - Balto. - Md. - 21225					
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial				July 31, 1972		Mt. Nebo		Delta York Penna.	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
AUG 8 1972				Sidney H. Harkins		JOHN H. HARKINS Delta, Pa.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07517		72 07517	
72 07517				CERTIFICATE OF DEATH		REG. NO.	
BIRTH NO.				STATE OF MARYLAND-DEMH			
1. NAME OF DECEASED (Type or Print) ANNA KALTENBACH				2. DATE AND HOUR OF DEATH 08-04-72 09.00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1510			
FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL - BALTO. MD.		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 37		C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4102 LIBERTY HTS.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03-01-1889	9. AGE (In years last birthday) 83	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U.S.A. (MD)		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME JOSEPH KAUFMANⁿ				
14. MOTHER'S MAIDEN NAME CATHERINE XXXXXX -Soeder			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS William H. Kaltenbach, Jr.				
18. 562111				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE PULMONARY EMBOLI - RT LUNG DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DIVERTICULITIS - SIGMOID COLON DUE TO, OR AS A CONSEQUENCE OF: RESECTION			
				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				ADVANCED ASCVP -			
19A. DATE OF OPERATION 08-02-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED DIVERTICULITIS SIGMOID COLON		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/21 19 72 to 8/4 19 72 that (I) (we) last saw the deceased alive on 08-04 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Gustavo Roca Roca				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 08-05-72	
23C. PHYSICIAN'S NAME (Type) GUSTAVO ROCA Roca				23D. ADDRESS MERCY HOSP. BALTO. MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/72		24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1972		25B. NAME OF REGISTRAR Edw. J. Johnson		25C. FUNERAL DIRECTOR ADDRESS Armacost Funeral Chapel, 4600 Liberty Heights Avenue, Balto. Md. 21207			

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(2A) A2U

CATERING 2814

28 1931-10-20

28 1931-10-20

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28 1931-10-20

28 1931-10-20

28 1931-10-20

28 1931-10-20

28 1931-10-20

28 1931-10-20

28 1931-10-20

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-6301

72 07518

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

STATE OF MARYLAND-DHMH

72 07518

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Prouty, Charles

2. DATE AND HOUR OF DEATH

August 3, 1972

10:02 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION
Provident Hospital, Inc.
2600 Liberty Height Ave.
Baltimore, Md. 21215

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE
B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

4700 Liberty Height Ave.

5. SEX

Male

6. RACE

White

7. MARRIED ☐

NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

2-2-6

9. AGE (In years last birthday)

66

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Handyman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Prouty

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

212-18-1424

17. INFORMANT

John Hayes -8316 Lages Lane

ADDRESS

21207

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Cardiopulmonary Arrest

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

Cardiogenic Shock

Acute Myocardial infarction

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from August 3, 19 72 to August 3, 19 72 that (I) (we) last saw the deceased alive on August 3, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Loat M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

August 3, 1972

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

Provident Hospital 2600 Liberty Height Ave.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE 8-8-72

24C. NAME of CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

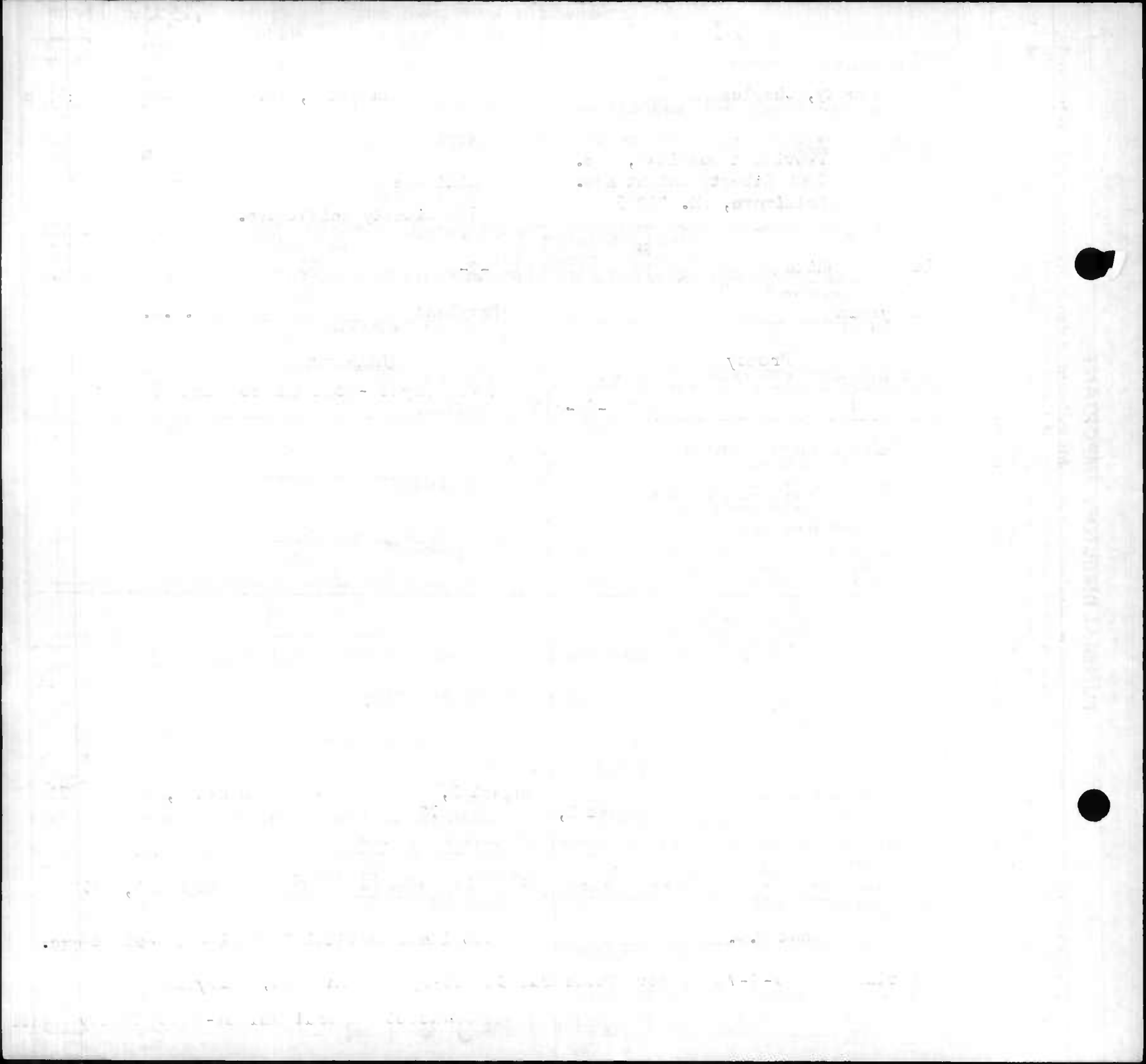
AUG 8 1972

25B. NAME OF REGISTRAR

Loat M.D.

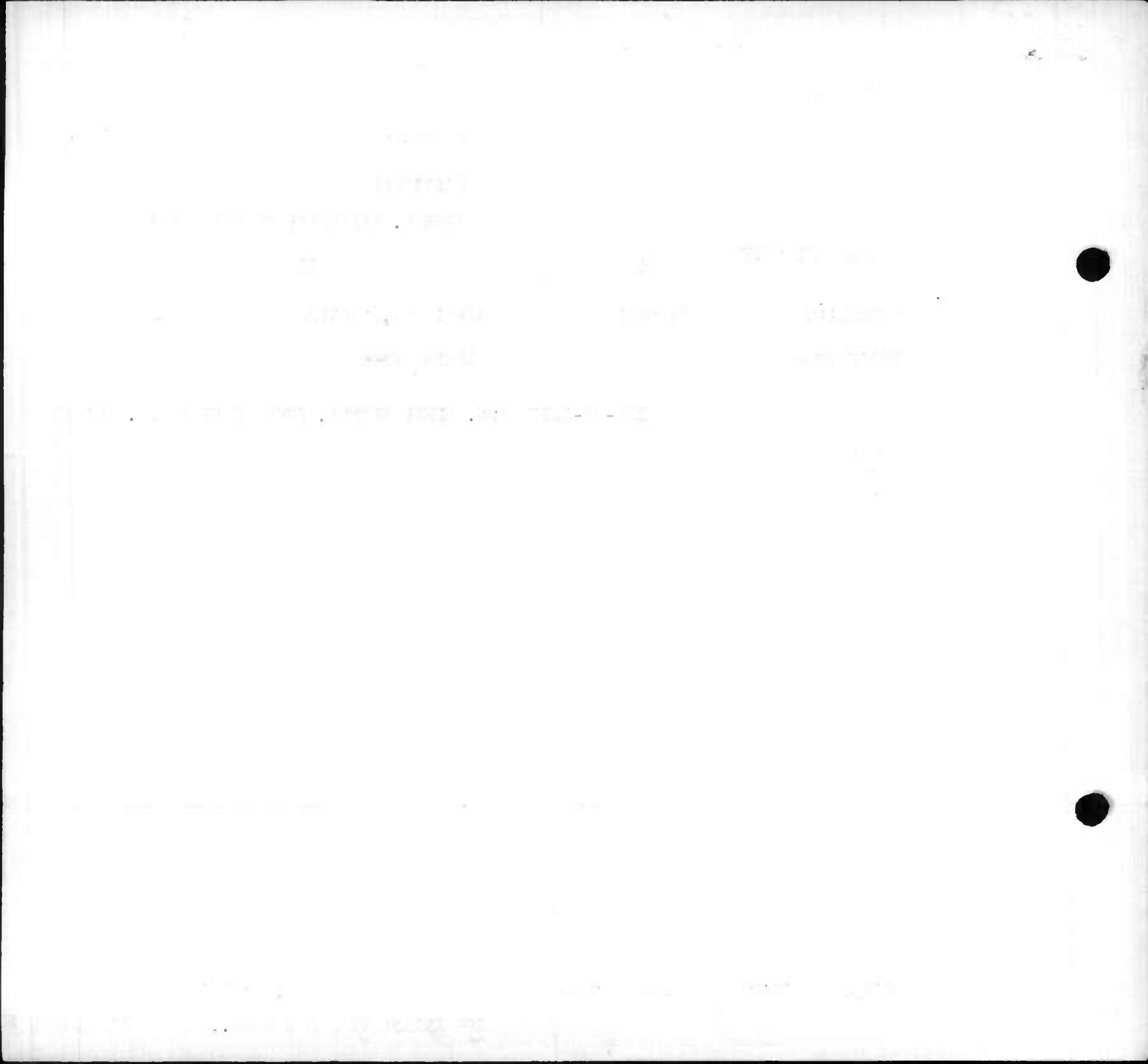
25C. FUNERAL DIRECTOR

Armacost Funeral Chapel-4600 Liberty Hghts



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07519		REG. NO. 72 07519	
CERTIFICATE OF DEATH							
STATE OF MARYLAND-DEM							
BIRTH NO.		1. NAME OF DECEASED (Type or Print) LERNER ADNA		2. DATE AND HOUR OF DEATH 8/2/72 6:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sidai Hosp. of Baltimore, Inc.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2717			
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
		E. STREET AND NUMBER 2505 W. BELVEDERE AVENUE #21215					
5. SEX FEMALE	6. RACE XX WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ISAAC BROWN				14. MOTHER'S MAIDEN NAME ZELDA RICH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-44-2537		17. INFORMANT ADDRESS MRS. MENDE LERNER, 3209 MIDFIELD RD. #21208			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: Complete heart block		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 hrs.	
				(B) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF:		sev. years.	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/1 19 72 to 8/2 19 72 that (I) (we) last saw the deceased alive on 8/2 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Veneranda C. Gerasmio, m.d.				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) Veneranda C. Gerasmio, m.d.				23D. ADDRESS Sidai Hosp. of Balt., Inc.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE BURIAL 8/3/72		24C. NAME OF CEMETERY or CREMATORY SHOMRE ADATH		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1972		25B. NAME OF REGISTRAR Sidney Indur...		25C. FUNERAL DIRECTOR SOL FRANKLEINSON & BROS., 6010 REISTERSTOWN RD.		ADDRESS	



S-600

72 07520 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07520

BIRTH NO.

STATE OF MARYLAND-DHMH

1. NAME OF DECEASED
(Type or Print)

EMANUEL SCERRA

2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ July 28 1972 M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
OR INSTITUTION

31 City Hosp.

3. DATE PRONOUNCED DEAD Month Day Year Hour
7 28 1972 9:25p M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. ~~STATE~~ Italy B. COUNTY V 66

6. SEX

male

7. RACE

white

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

GELA

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

Aug. 30, 1915

10. AGE (In years last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

19 South St. c/o Texas Transport Terminal

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF
WHAT COUNTRY?
ITALY

13. FATHER'S NAME

SAVERIO SCERRA

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SEAMAN

14B. KIND OF BUSINESS OR INDUSTRY

MERCHANT SHIPPING.

15. MOTHER'S MAIDEN NAME

CONCETTA LA LUMIA

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
NO.

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

TIDEWATER COM. CO. INC. 201 N. CHARLES. ST.

19.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Blunt force injury to chest & abdomen

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIBUTING
CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
pier22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Bethlehem Steel Co.22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)
7-28-72 2:30 p.m.

22E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

Subj. working on "high pier" when

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

he was struck with a hose and thrown from ship to cement pier.

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-30-72

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8/20/72

24C. NAME of CEMETERY or CREMATORY

GELA.

24D. LOCATION (City, town, or county)

GELA ITALY.

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 8 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

322 S. HIGH ST.

22

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07521

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07521

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CELIA FOREMAN

2. DATE AND HOUR OF DEATH

AUGUST 2, 1972

8:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

MT. SINAI NURSING HOME

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

6214 CROSS COUNTRY BLVD.

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday)

85

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

RUSSIA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

MRS. BESSIE L. KELLMAN, 6214 CROSS COUNTRY BLVD

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cerebral Arteriosclerosis

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Senility

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1965 to 8/2 1972, that (I) (we) last saw the deceased alive on 8/2 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Edward S. Kallins MD

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

8/3/72

23C. PHYSICIAN'S NAME (Type)

EDWARD S. KALLINS

23D. ADDRESS

6000 PARK HEIGHTS AVENUE

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8/4/72

24C. NAME OF CEMETERY OR CREMATORY

HAR SINAI BENEVOLENT SOCIETY

24D. LOCATION

(City, town, or county)

ROSEDALE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

AUG 8 1972

25B. NAME OF REGISTRAR

Sidney Levinson

25C. FUNERAL DIRECTOR

SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

ADDRESS

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07522

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07522

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MEIER, Richard

2. DATE AND HOUR OF DEATH

8/3/72

10⁰⁰ A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3002 Fallstaff Manor Ct. Apt. 1

5. SEX

Male

6. RACE

Cauc.

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

7/02/01

9. AGE in years (last birthday)

71

10. Under 1 Yr. Months Days

11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

MERCHANT

10B. KIND OF BUSINESS OR INDUSTRY

RETAIL

11. BIRTHPLACE (State or foreign country)

GERMANY

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Herman Meier

14. MOTHER'S MAIDEN NAME

Sarah Walker

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

MRS. IRMA MEIER, 3002 FALLSTAFF MANOR CT., APT. 1

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Cardiac Arrest

20 minutes

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) Arrhythmia or Bradycardia

15 minutes

DUE TO, OR AS A CONSEQUENCE OF:

(C) Myocardial Infarction(?)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Anuria, Respirator dependent, pneumonia 3 wks

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 19 to 8/3/72 19 72 that (2) (we) last saw the deceased alive on 8/3/72 19 72 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.

23A. SIGNATURE

David Bouman, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

8/3/72

23C. PHYSICIAN'S NAME (Type)

David Bouman,

M.D.

23D. ADDRESS

The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8/4/72

24C. NAME OF CEMETERY OR CREMATORY

CHEVRA AHAVAS GESSED

24D. LOCATION

(City, town, or county)

(State)

RANDALLSTOWN, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

AUG 8 1972

25B. NAME OF REGISTRAR

Sidney Levinson

25C. FUNERAL DIRECTOR

SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

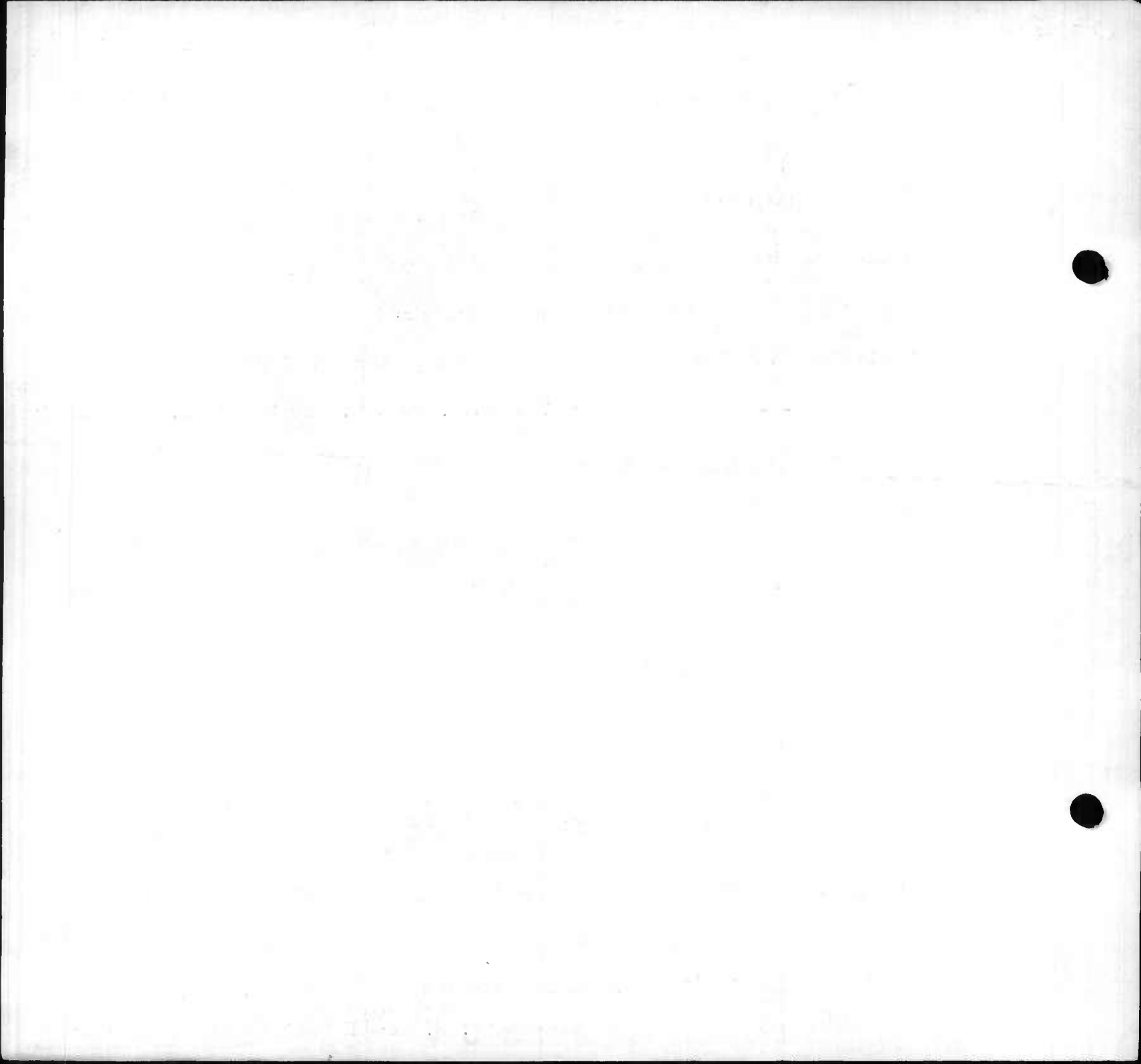
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72 07523

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 07523

BIRTH NO. ELMER		2. DATE AND HOUR OF DEATH August 4, 1972 16:30 A M.	
1. NAME OF DECEASED (Type or Print) Joseph E. Bullock		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 275-8	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1707 A Waverly Way #39	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03/31/90
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Power Man		10B. KIND OF BUSINESS OR INDUSTRY C & P Telephone	9. AGE (In years last birthday) 82
13. FATHER'S NAME Edwin Bennett Bullock		11. BIRTHPLACE (State or foreign country) Maryland	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212 03 6703	
17. INFORMANT Mrs. Mary H. Bossle		ADDRESS 1819 E. Northern Park Way	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF: 1 hr. (B) Metastatic Ca of prostate DUE TO, OR AS A CONSEQUENCE OF: 12 hrs. (C) CVA 4 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/30/72 19 to 8/4 1972 that (I) (we) last saw the deceased alive on 8/4 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Michael Ference III M.D.		23B. DATE SIGNED 8/4/72	
23C. PHYSICIAN'S NAME (Type) Michael Ference III, M.D.		23D. ADDRESS 24-E Wyndmoor Pl, Baltimore, Md. 21207	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Aug 7, 1972	24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1972	25B. NAME OF REGISTRAR Dorothy Whitton	25C. FUNERAL DIRECTOR J. B. Lowell Lemmon ADDRESS 6500 York Road	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-000 1		72 07524		BALTIMORE CITY HEALTH DEPARTMENT		72 07524	
CERTIFICATE OF DEATH				REG. NO.			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND-DHMT	
		JOY, JOHN L.		8-4-72		240 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
BON SECOURS HOSPITAL				MARYLAND 1802			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				105 N. CAREY ST.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.	
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	5-09-00	72			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired				Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MARRIED NAME			
Joseph Joy				Pauline Cusic			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		705-12-6315		Madeline West		2400 Colburn St.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Pulmonary disease may be T.B. 4 days			
DUE TO, OR AS A CONSEQUENCE OF:				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8/1/72 19 to 8/4/72 19 that (I) (we) last saw the deceased alive on 8/4/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
CHAIRMAN				8/4/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-7-72		Cedar Hill Cemetery		Suitland (Pr. Geo.) Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 8 1972		Sidney Johnston		Simmons Funeral Home		1661 Good Hope Rd SE WASH DC	

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BALTIMORE CITY HEALTH DEPARTMENT STATE OF MARYLAND-DEM
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07525

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Thomas Norton

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month 7

Day 25

Year 72

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 2010 N. Charles St.

3. DATE
PRONOUNCED DEAD

Month 7

Day 25

Year 72

Hour 10:05 a.

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md. 2010 N. CHARLES ST BALTO, MD

B. COUNTY

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

7-7-7

10. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2010 N. Charles St.

1206

11. BIRTHPLACE (State or foreign country)

BALTO. MD.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNKNOWN

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

UNKNOWN

14B. KIND OF BUSINESS OR INDUSTRY

UNKNOWN

15. MOTHER'S MAIDEN NAME

UNKNOWN

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

UNKNOWN UNKNOWN

17. SOCIAL
SECURITY NO.

235-187-165

18. INFORMANT

JAMES LIBERTINI-320 CATHEDRAL ST.

ADDRESS

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Heat Stroke

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Hypertensive and arteriosclerotic cardiovascular disease

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes- partial

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIBUTING
CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

HOME

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2010 N. Charles St.

22D. TIME OF INJURY
(APPROX.)

(Month) 7

(Day) 25

(Year) 72

(Hour) unk

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Apparent heat stroke during heat wave

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/25/72

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

AUG 4-72

24C. NAME of CEMETERY or CREMATORY

NEW CATHEDRAL

24D. LOCATION (City, town, or county)

OLD FREDERICK RD

(State)

MD

25A. DATE REC'D BY HEALTH DEPT.

AUG 8 1972

25B. NAME OF REGISTRAR

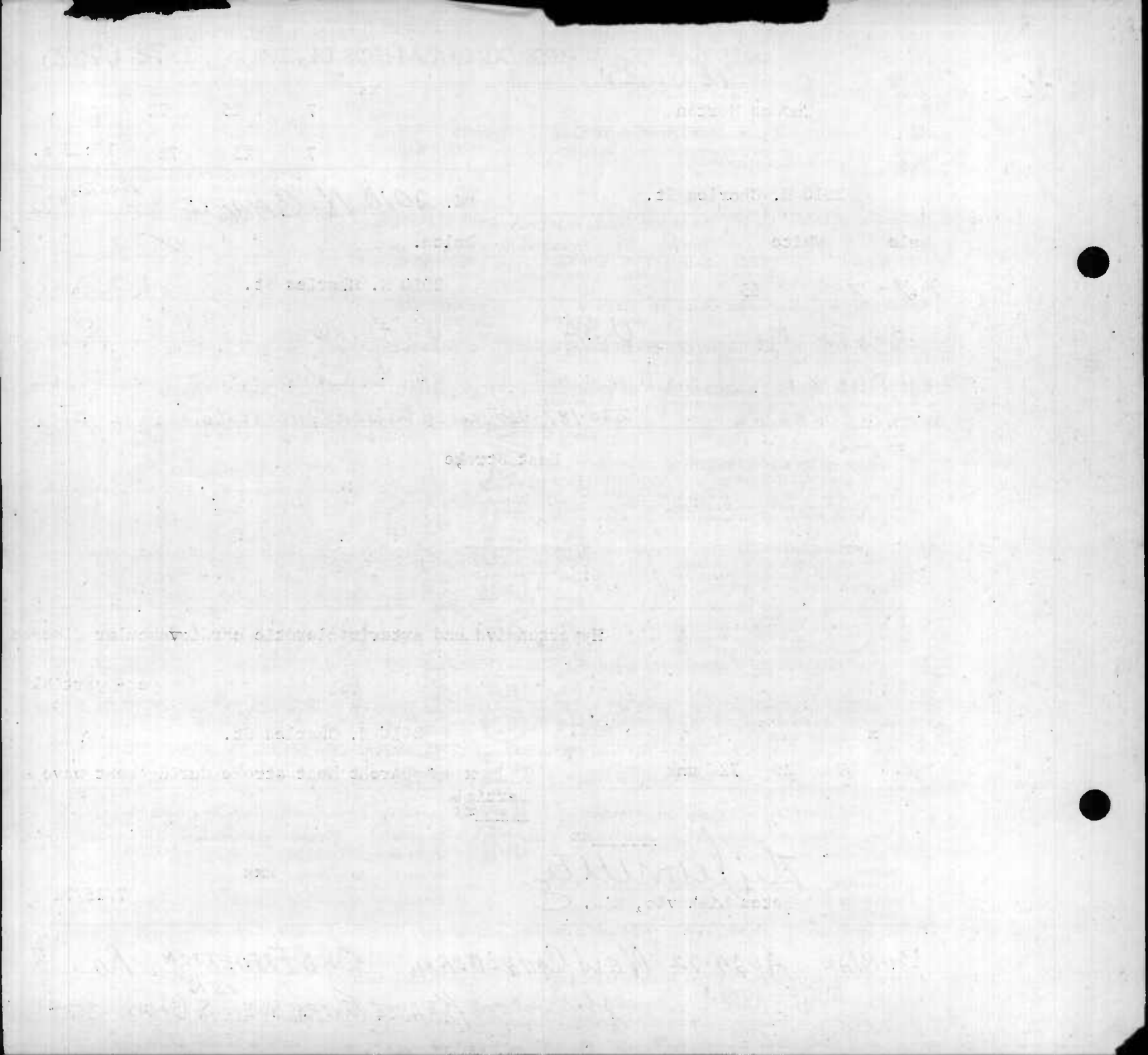
Sidney Winston

25C. FUNERAL DIRECTOR

KRAUSE FUNERAL HOME

ADDRESS

1276 S. CHAS. ST



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07526
72 07526				STATE OF MARYLAND-DHMH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WALKER, LEWIS RAYMOND		
2. DATE AND HOUR OF DEATH AUGUST 5, 1972		6:55AM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Howard		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		C. CITY OR TOWN MARRIOTTSVILLE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER BOX 12000 HOWARD COUNTY 21104				
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 05/30/01	9. AGE (In years last birthday) 71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY LANDSCAPING		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U S A				
13. FATHER'S NAME WILLIAM WALKER		14. MOTHER'S MAIDEN NAME VIRGINIA GORDON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220 07 7518		17. INFORMANT ST AGNES HOSPITAL BALTO MD 21229
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pneumonia Carcinoma of the bladder resected Ascendovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 08/03/72 19 to 08/05/72 19, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 08/05/72 19 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.				
23A. SIGNATURE Benaides M.D.				23B. DATE SIGNED 8/5/72
23C. PHYSICIAN'S NAME (Type) VICTOR BENAVIDES M.D.		23D. ADDRESS ST. AGNES HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Aug. 8, 1972		24C. NAME OF CEMETERY or CREMATORY Providence
24D. LOCATION Glenelg, Howard, Md				
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1972		25B. NAME OF REGISTRAR Frederick W. Houston		25C. FUNERAL DIRECTOR Slack Funeral Home, Ellicott City, Md

1942

August 2, 1942

August 11, 1942

Memphis

Memphis

St. Agnes Hospital

St. Agnes Hospital

St.

St.

St. Agnes Hospital

St. Agnes Hospital

St. Agnes Hospital

St. Agnes Hospital

St. Agnes Hospital

St. Agnes Hospital

St. Agnes Hospital

St. Agnes Hospital

St. Agnes Hospital

FUNERAL DIRECTOR: IMPORTANT

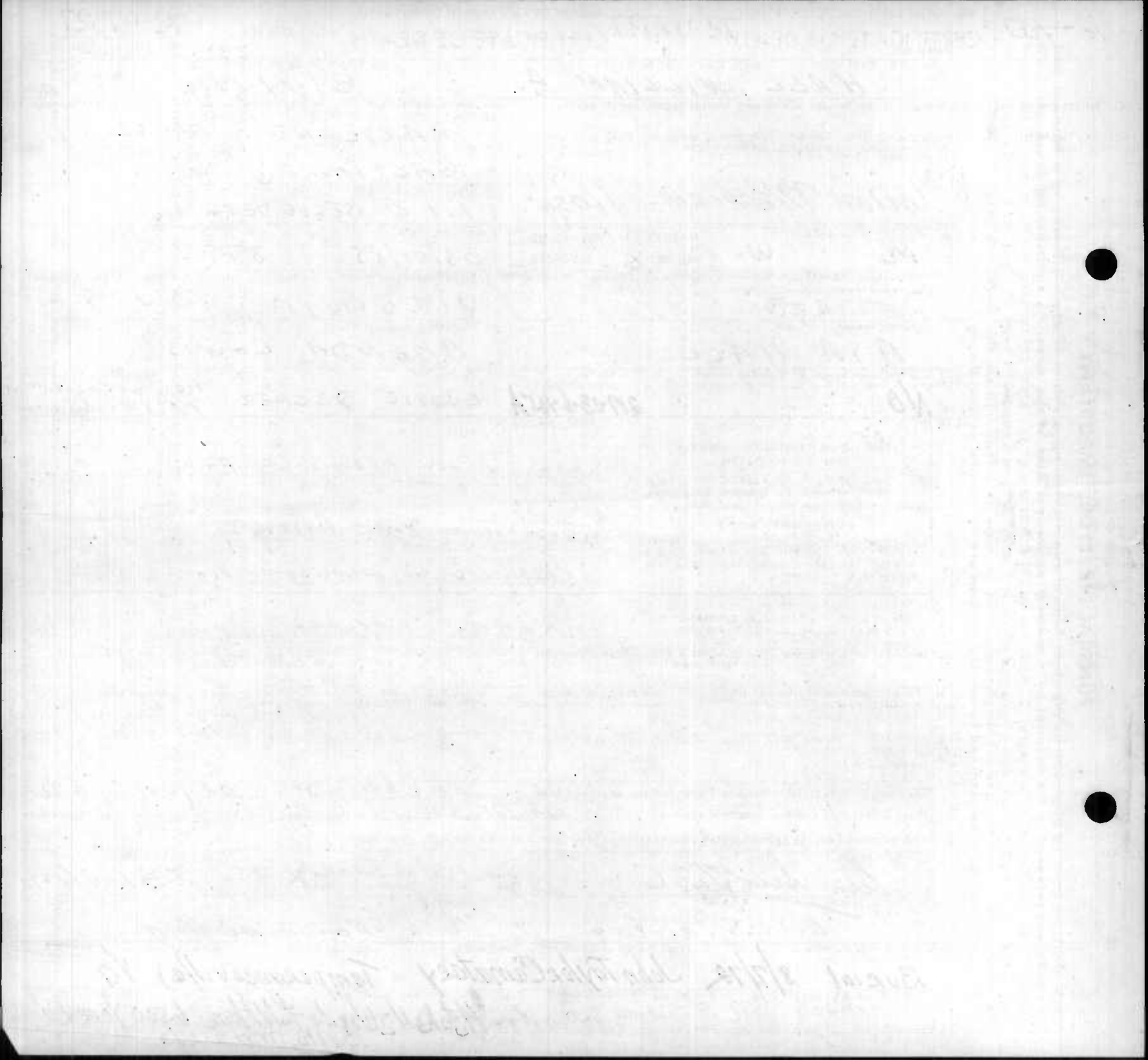
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 07527
STATE OF MARYLAND-DEM

BIRTH NO. 72 07527

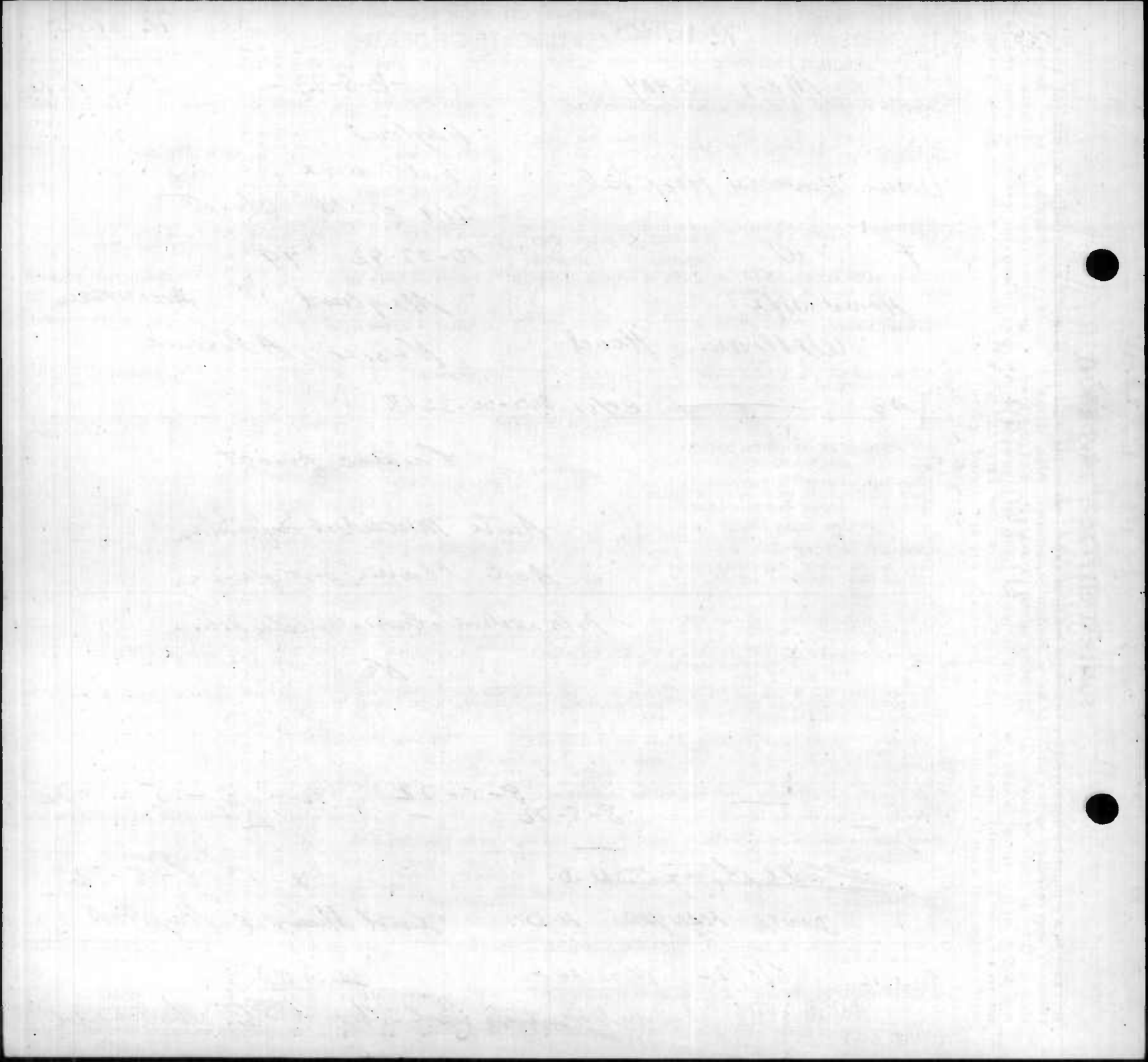
1. NAME OF DECEASED (Type or Print) <u>HALL, WILLIAM A.</u>		2. DATE AND HOUR OF DEATH <u>8/4/1972 2.30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>21212</u>	
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>03/01/85</u> 9. AGE (In years last birthday) <u>87</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
13. FATHER'S NAME <u>ASA HALL</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>91703-6485A</u>	
17. INFORMANT <u>LOUISE DECKER</u>		ADDRESS <u>1101 N. CALVERT ST. APT. 1704 BALTO MD.</u>	
18. CAUSE OF DEATH <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>RENAL FAILURE</u>			
19A. DATE OF OPERATION <u>8/12/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CARDIO - RESPIRATORY Arrest.</u>	
20A. AUTOPSY? (Yes or No) <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>INJURY OCCUR?</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>07/28 1972</u>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>08/04/72 1972</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>07/28 1972</u> to <u>08/04/ 1972</u> , that (I) (we) lost saw the deceased alive on <u>08/04/72 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Luis Sirovsky</u>		23B. DATE SIGNED <u>08/04/1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>Luis Sirovsky</u>		23D. ADDRESS <u>Union Memorial Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/7/72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>John Taylor Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Tamperanceville, Va</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1972</u>		25B. NAME OF REGISTRAR <u>Andrew Andrew Mitchell</u>	
25C. FUNERAL DIRECTOR <u>Wanda Feld Home</u>		ADDRESS <u>6500 York Rd Balto, Md 21212</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 07528</u>	
72 07528				STATE OF MARYLAND-DEM	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<u>MARY SHAY</u>		<u>8-5-72 - 8:00 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> <u>44</u>				A. STATE <u>Maryland</u>	
				B. COUNTY <u>Baltimore</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>719 Field Street</u>				9. AGE (In years last birthday) <u>79</u>	
				10. AGE (In years last birthday) <u>79</u>	
5. SEX <u>F.</u>	6. RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-23-92</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Hood</u>				14. MOTHER'S MAIDEN NAME <u>Nrsler, Alexine</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>8485 800-00-3268</u>		17. INFORMANT ADDRESS	
18. <u>7109 I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac Arrest.</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Arteriosclerotic Cardio Vascular Disease</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nately medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-5-72</u> 19 <u>72</u> to <u>8-5-1972</u> , that (I) (we) last saw the deceased alive on <u>8-5-72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dante Mangari M.D.</u>				23B. DATE SIGNED <u>8-5-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>DANTE MANGARI M.D.</u>				23D. ADDRESS <u>Union Memorial Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/8/72</u>		24C. NAME of CEMETERY or CREMATORY <u>WOODLAWN</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO, MD.</u>					
25A. DATE REC'D. BY HEALTH DEPT. <u>AUG 8 1972</u>		25B. NAME OF REGISTRAR <u>Sidney J. [unclear]</u>		25C. FUNERAL DIRECTOR <u>Paul J. [unclear]</u>	
				ADDRESS <u>5617 Chestnut Ave.</u>	



1

72 07529

BALTIMORE CITY HEALTH DEPARTMENT

72 07529

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DEMH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

William Michael Butler

2. DATE OF DEATH

Known ☒ Estimated ☐

Month Day Year

8 3 72

Hour

12:50 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital

3. DATE PRONOUNCED DEAD

Month Day Year

8 3 72

12:50 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

1502

6. SEX

Male

7. RACE

Negro

8. MARRIED

☐ NEVER MARRIEDWIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

3-17-49

10. AGE (In years last birthday)

23

11. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1615 N. Payson Street

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Lewis Butler

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Rose

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

216-52-5742

18. INFORMANT

Queenie Butler

ADDRESS

Same

19.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE Gunshot wound of chest
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

taxi cab

22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?

1900 blk. Pulaski St.

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

8 3 72 12:45 P.M.

22E. INJURY OCCURRED

WHILE AT WORK ☒NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

shot by unknown assailant

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

W P Mulloy M.D.
*William P. Mulloy, M.D.*CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-4-72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/8/72

24C. NAME OF CEMETERY or CREMATORY

Arbutus Mount

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 8 1972

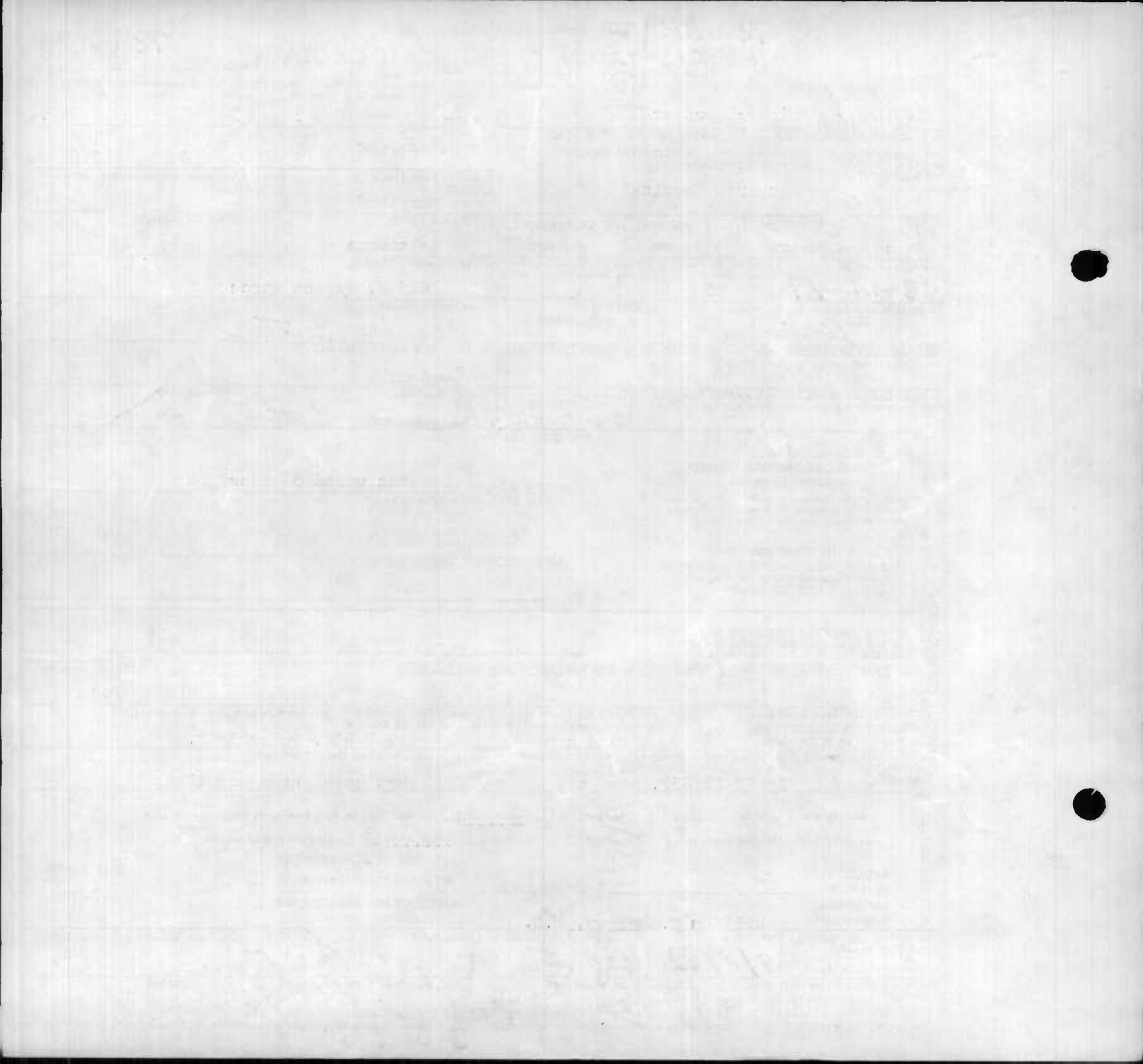
25B. NAME OF REGISTRAR

Disney Whitton

25C. FUNERAL DIRECTOR

Delington S. Phelps 1727 N. Mount

ADDRESS



5-5361

72 07530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 07530

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SMITH ALICE

2. DATE AND HOUR OF DEATH

8-7-72

6.25

P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Union MEMORIAL HOSPITAL
332nd and Calvert St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

1907 HOMEWOOD AVE, BALTIMORE, 18, MD

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

HOMEWOOD

1907

908

5. SEX

F

6. RACE

B

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

4-10-08

9. AGE (In years
last birthday)

64

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

-

14. MOTHER'S MAIDEN NAME

-

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

217-03-0001

17. INFORMANT

ADDRESS

RANDOLF JACKSON 1907 Homewood St.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF: ?

? Pulmonary emboli

(B) C.H.F. ? Diabetic acidosis.

DUE TO, OR AS A CONSEQUENCE OF: ?

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8-6-72 10:45 PM to 8-7-72 6:25 AM
that (I) (we) last saw the deceased alive on 8-7-72 19 72 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M. Yazdani

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8-7-72

23C. PHYSICIAN'S
NAME (Type)

MAHMOUD YAZDANI

DEGREE

23D. ADDRESS

UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-10-72

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Cem

24D. LOCATION

(City, town, or county)

(State)

Anne Arundel City Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 8 1972

25B. NAME OF REGISTRAR

Audrey Johnston

25C. FUNERAL DIRECTOR

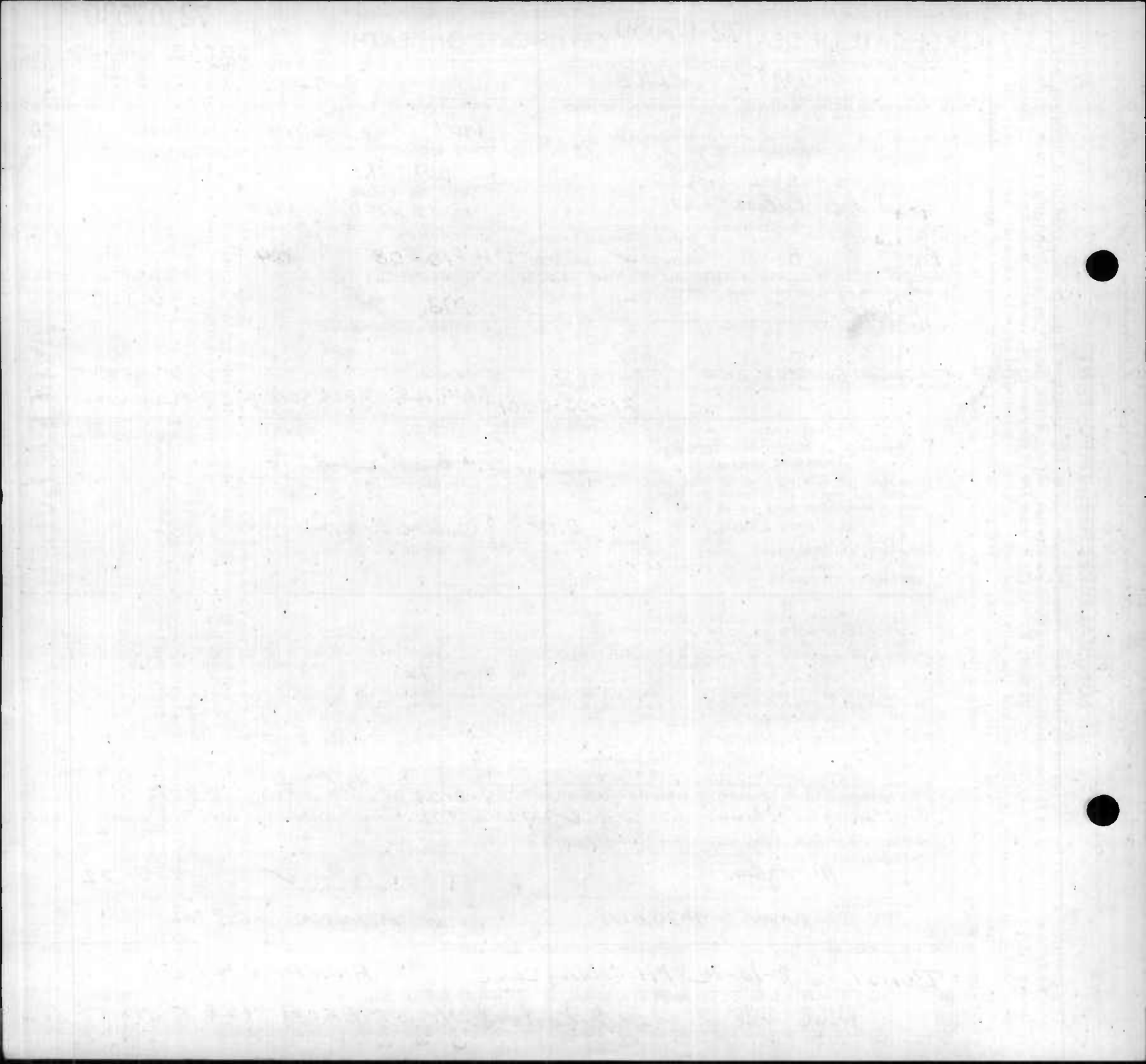
WM C MARCH 928 E North Ave

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

8-7-72 Released by medical examiner M. Yazdani



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07531

BIRTH NO.

STATE OF MARYLAND-DEMH

1. NAME OF DECEASED (Type or Print) DANIEL PEARSON				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3516 W. Belvedere Ave.				3. DATE PRONOUNCED DEAD Month Day Year Hour 8 6 1972 1:15p M.			
6. SEX male				7. RACE negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 4-8-40				10. AGE (In years lost birthday) 32		11. BIRTHPLACE (State or foreign country) S.C.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Marion Pearson		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2788	
15. MOTHER'S MAIDEN NAME Pearl Shaw				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
17. SOCIAL SECURITY NO. 250-62-3466				18. INFORMANT ADDRESS Shirley Pearson 218 E. 22nd Street			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Idiopathic cardiomyopathy ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8-7-72 EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-11-72		24C. NAME of CEMETERY or CREMATORY Sumter, S.C.		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1972		25B. NAME OF REGISTRAR Sidney Johnston		25C. FUNERAL DIRECTOR Wm C March		ADDRESS 928 E North Ave.	

12-15-57

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07532 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 07532	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) OGDEN, JOSEPH L. OGDEN		2. DATE AND HOUR OF DEATH 8/7/72 2:30 A	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 8-8-72		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO.			
FULL NAME OF HOSPITAL OR INSTITUTION (If in hospital or institution, give street address or location) UNIV. OF MARYLAND HOSPITAL		C. CITY OR TOWN BALTO. MD.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1109 Sargeant St.		F. ZIP CODE 2102			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/6/93	9. AGE (In years last birthday) 79	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cinder		10B. KIND OF BUSINESS OR INDUSTRY Stream Int Co		11. BIRTHPLACE (State or foreign country) Ind.	
13. FATHER'S NAME James Ogden		14. MOTHER'S MAIDEN NAME Julia Collinson		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-05-7407A		17. INFORMANT Lina Hudson ADDRESS 1110 Sargeant St.	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE CARDIAC + RESPIRATORY ARREST - 10 min DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) RENAL FAILURE			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). PERIPHERAL VASCULAR DISEASE					
19A. DATE OF OPERATION 8/2/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED DRY GANGRENE		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/29 19 72 to 8/7 19 72 that (I) (we) last saw the deceased alive on 8/7 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lina Hudson M.D.		23B. DATE SIGNED 8/7/72		23C. PHYSICIAN'S NAME (Type) Lina Hudson	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/19/72		24C. NAME OF CEMETERY OR CREMATORY Int. Olmit Cem.	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1972		25B. NAME OF REGISTRAR Anthony Johnson		25C. FUNERAL DIRECTOR John G. Cowan & Son Inc. ADDRESS Hollins St.	

8-8-1972 - Correction form from Funeral Director - John J. Cowan & Sons, Inc.
901 Hollins Street, Balto., Md. 21223

HRS

PT

EP

John J. Cowan & Sons, Inc.

Funeral Director

901 Hollins Street

Baltimore, Md. 21223

-

11

John J. Cowan & Sons, Inc.

Funeral Director

901 Hollins Street

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07533

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07533

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MURRAY, Nesbit J.

2. DATE AND HOUR OF DEATH

Aug 5, 1972

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3313 Poplar Street
Hilton Nursing

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

5. STATE 8. COUNTY

C. CITY OR TOWN

E. STREET AND NUMBER

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

5. SEX

M

6. RACE

B

7. MARRIED

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

5-3-97

9. AGE (In years last birthday)

74 1/2

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

240-106734A

17. INFORMANT

Wilhelmina Foy 1176 Lincoln Pl. SE, Brookridge, N. W.

ADDRESS

18. 412.4 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/27/72 19 to 8/5/72 19, that (I) (we) last saw the deceased alive on 8/5/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

HOLLIS SCUNAKINE, M.D.

Attending Phys. ☐

Med. Director ☒

Staff Phys. ☐

23B. DATE SIGNED

8/5/72

23D. ADDRESS

1801 Greenway Rd. Balt., Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Aug 10, 72

24C. NAME OF CEMETERY OR CREMATORY

BALTIMORE CEM

24D. LOCATION

Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 8 1972

25B. NAME OF REGISTRAR

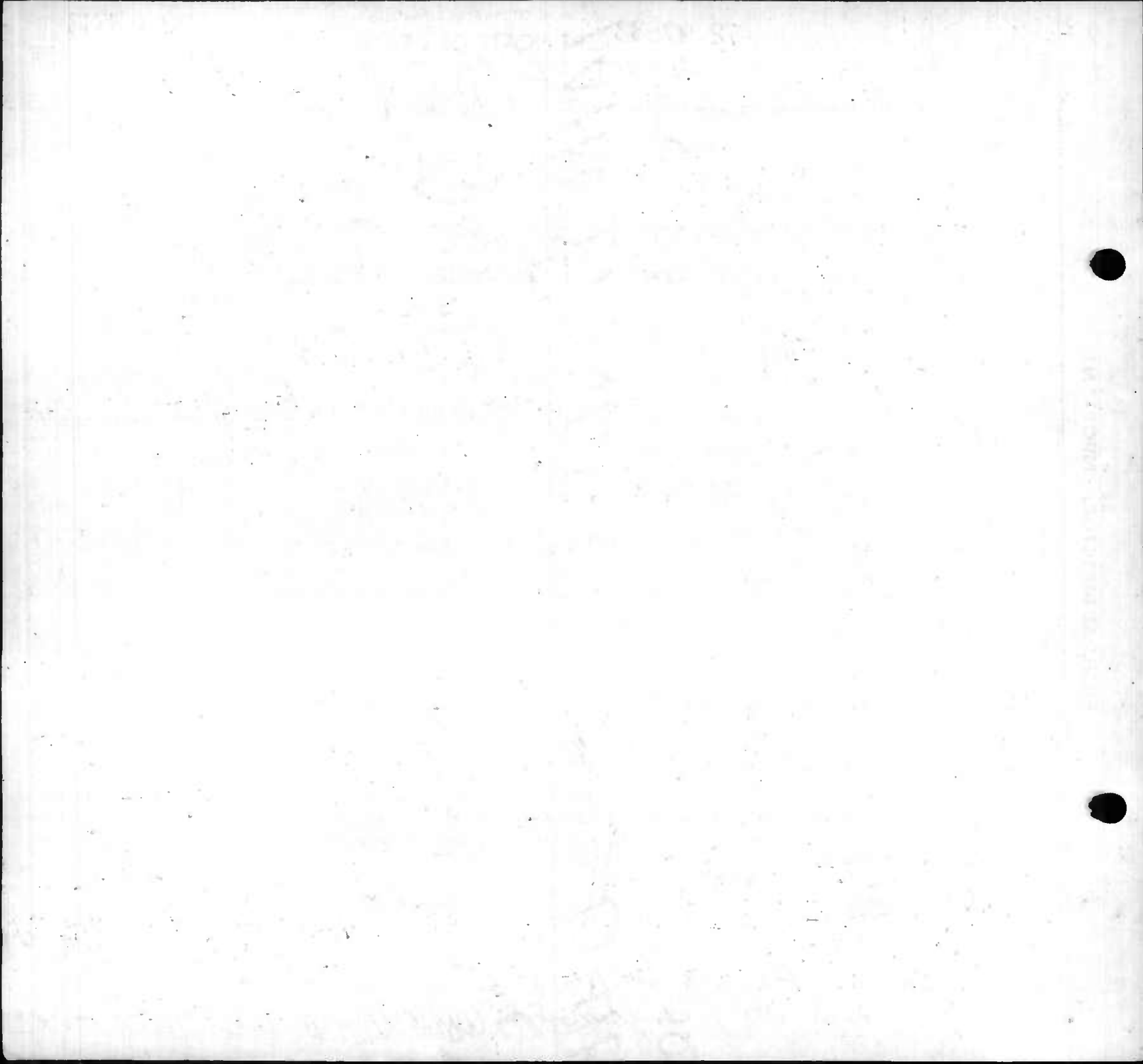
Ludwig W. Houston

25C. FUNERAL DIRECTOR

Wm S. March

ADDRESS

928 E. North Ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07534	
72 07534 CERTIFICATE OF DEATH					
BIRTH NO.		STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
JANE Elizabeth CLAYTOR		8/6/72 12:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UPLAND HOME FOR CHURCH WOMEN		A. STATE Md		B. COUNTY Baltimore	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
90		E. STREET AND NUMBER 4501 Old Frederick Rd.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/2/1878	9. AGE (In years last birthday) 93	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Baltimore Md. USA	
13. FATHER'S NAME Josiah THOMAS		14. MOTHER'S MAIDEN NAME India ARNOLD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-09-8255		17. INFORMANT Isabelle Plangley Director	
18. 43791 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis indeterminate cerebro-cardiovascular disease			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 1964 to Aug 1972, that (H) (we) lost saw the deceased alive on 6 Aug 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Laurence Gallagher, M.D.				23B. DATE SIGNED 6 Aug 72	
23C. PHYSICIAN'S NAME (Type) LAURENCE R. GALLAGHER M.D.				23D. ADDRESS ST AGNES MED CTR WILKENS - PINE HEIGHTS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/72		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION Pikesville, Maryland		24E. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue		24F. ADDRESS 21228	
25A. DATE REC'D BY HEALTH DEPT. 1972000		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

1
H-200

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07535

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) GEORGE A. HAYNES HAYS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour August 5, 1972 8:35 A.	
6. SEX Male		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE White		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 7/20/09		10. AGE (In years lost birthday) 63	
11. BIRTHPLACE (State or foreign country) Pittsburgh, Pa.		12. CITIZEN OF USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor		14B. KIND OF BUSINESS OR INDUSTRY B & O	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 159-18-3126	
15. MOTHER'S MAIDEN NAME Florence Thompson		18. INFORMANT Mrs. Margaret Hays, 1204 Edmondson Ave. 21228	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/72	
24C. NAME of CEMETERY or CREMATORY Green Mount Cemetery		24D. LOCATION (City, town, or county) (State) Cumberland, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue 21228		ADDRESS	

THE UNIVERSITY OF CHICAGO

CHICAGO, ILL.

DEPARTMENT OF CHEMISTRY

1925

TO THE HONORABLE CHAIRMAN

OF

THE BOARD OF TRUSTEES

OF THE UNIVERSITY

OF CHICAGO

IN RESPONSE TO A RESOLUTION

PASSED AT A MEETING OF THE BOARD

HELD AT CHICAGO, ILL.

ON JANUARY 15, 1925

AND IN ANSWER TO A RESOLUTION

PASSED AT A MEETING OF THE BOARD

CHICAGO, ILL.

DEPARTMENT OF CHEMISTRY

1925

CHICAGO, ILL.

CHICAGO, ILL.

N-400

744-2131

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 07536		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07536	
1. NAME OF DECEASED (Type or Print) NEWELL, LLOYD GEORGE		2. DATE AND HOUR OF DEATH AUGUST 4, 1972 4:50 PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 218 STONEWALL ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 17 16	9. AGE (In years lost birthday) 55	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MARYLAND PRINTING TECHNICAL REPRESENTATIVE CO.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CANADA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME SAM NEWELL		14. MOTHER'S MAIDEN NAME MARY (KANT)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WORLD WAR 11		16. SOCIAL SECURITY NO. 153-01-9373		17. INFORMANT ST. AGNES HOSPITAL MEDICAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) 412.3 I Pump failure. Congestive Heart failure.		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) old history of Myocardial Infarction 1 year			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from AUGUST 1 19 72 to AUGUST 4 19 72, that <input checked="" type="checkbox"/> (we) lost saw the deceased olive on AUGUST 4 19 72 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE Harjit Singh M.D.		23B. DATE SIGNED 8/4/72		23C. PHYSICIAN'S NAME (Type) HARJIT SINGH M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 8/8/72		24C. NAME OF CEMETERY or CREMATORY Loudon Park Crematory	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue 21228		25D. ADDRESS			

AUGUST 1 1952

WELL, L. J. 2002

BALTIMORE 2 WY

219 STONEMILL ROAD

DR. AGNES HOSPITAL
WILKINS & CATON AVENUES
BALTIMORE, MARYLAND 21205

11-17-18

MALE WHITE

USA

AMERICAN PRINTING COMPANY

TECHNICAL REPRESENTATIVE

(NAME) (NAME)

JOHN HENRI

AT AGNES HOSPITAL BALTIMORE

11-17-18

YES WITH THE 11

27

AUGUST 1 1952

XX

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AUGUST 1 1952

XX

XX

XX

BALTIMORE, MARYLAND

DR. AGNES HOSPITAL

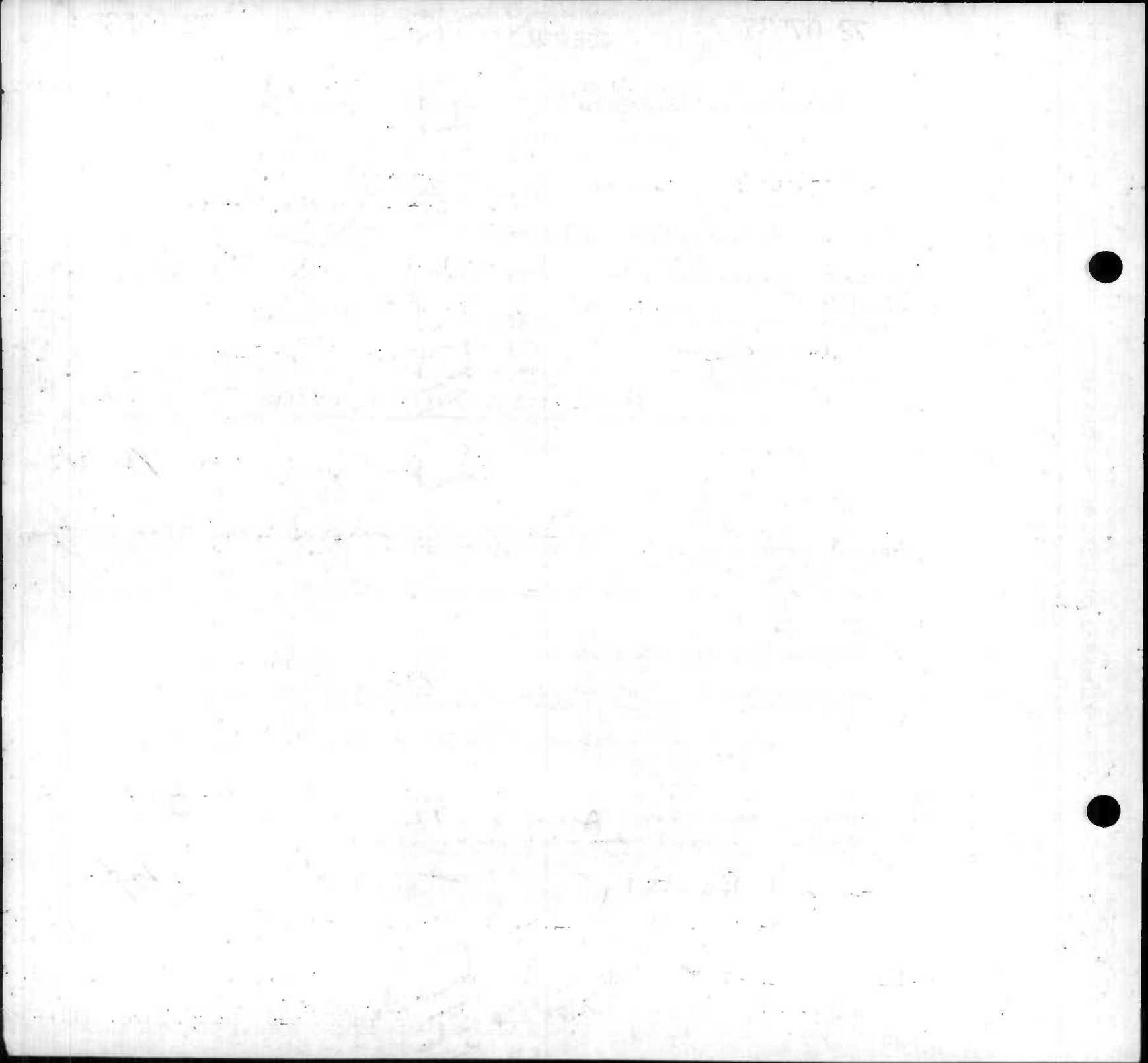
TECHNICAL REPRESENTATIVE

11-17-18

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07537	
<div style="display: flex; justify-content: space-between;"> T-360 1 72 07537 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Martha Anna Tudor			Aug. 7, 1972 2:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 622 Dumbarton Ave.			A. STATE Maryland B. COUNTY 901		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 622 Dumbarton Ave. 21218					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-6-1881	9. AGE (In years last birthday) 91	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Manchester, England		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Cooper			14. MOTHER'S MAIDEN NAME Elizabeth Sarah Tyson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-09-4119	17. INFORMANT Mrs. Myra Quick		ADDRESS Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 436.9 I Cerebral accident DUE TO, OR AS A CONSEQUENCE OF: Analyzed arteriosclerosis 5 yrs			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Two weeks		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 1978 to Aug 7 1972, that (I) (we) last saw the deceased alive on Aug 3 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Conrad L. Richter			23B. DATE SIGNED 8/7/72		
23C. PHYSICIAN'S NAME (Type) Conrad L. Richter M.D.			23D. ADDRESS 3128 Harford Road		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-9-72		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Balto., Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1972		25B. NAME OF REGISTRAR James W. Jenkins		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 07538				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07538	
STATE OF MARYLAND-DH&H				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>McCarthy, Timothy William</u>				2. DATE AND HOUR OF DEATH <u>Aug. 6 1972</u> <u>8:35 PM</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>The Union Memorial Hosp.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO 5300</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>4</u>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Towson</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>505 Locksley Round</u>	
5. SEX <u>male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1909</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGEMENT</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u>		11. BIRTHPLACE (State or foreign country) <u>CONNECTICUT</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>McCarthy, Patrick</u>			
14. MOTHER'S MAIDEN NAME <u>Ellen Cloze</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>219-42-6096</u>				17. INFORMANT <u>Mrs E. Ann McCarthy</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>Septicemia</u> <u>Septic Shock</u> <u>Septicemia</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Fracture of left femoral neck</u>							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>II</u>							
21A. DATE OF OPERATION <u>None</u>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		22A. AUTOPSY? (Yes or No) <u>no</u>		22B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
23A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		23B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		23C. WHERE DID INJURY OCCUR? <u>505 Locksley Rd.</u>		(If in Baltimore City, give exact location)	
24D. TIME OF INJURY (APPROX.) <u>7-21-72 12:00 PM</u>		24E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		24F. HOW DID INJURY OCCUR? <u>Fell in kitchen while walking</u>			
25. I certify that (I) (this hospital) attended the deceased from <u>July 21 1972</u> to <u>Aug 6 1972</u> , that (I) (we) last saw the deceased alive on <u>Aug 6 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
26A. SIGNATURE <u>Chung-Hsien Yu</u>				26B. DATE SIGNED <u>Aug 6, 1972</u>		26C. PHYSICIAN'S NAME (Type) <u>CHUNG-HSIEN YU</u>	
26D. ADDRESS <u>The Union Memorial Hospital</u>				26E. CITY <u>Baltimore, MD</u>		26F. STATE <u>21218</u>	
27A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		27B. DATE <u>8-9-72</u>		27C. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEMETERY</u>		27D. LOCATION (City, town, or county) (State) <u>WOODLAWN, BALTIMORE, MD</u>	
28A. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1972</u>		28B. NAME OF REGISTRAR <u>Frederick H. Burton</u>		28C. FUNERAL DIRECTOR <u>RAYMOND J. CURRAN</u>		28D. ADDRESS <u>517 SCARLETT DR. TOWSON, MD 21204</u>	

20th

11/11/68

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Blue

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7-11-11 1968

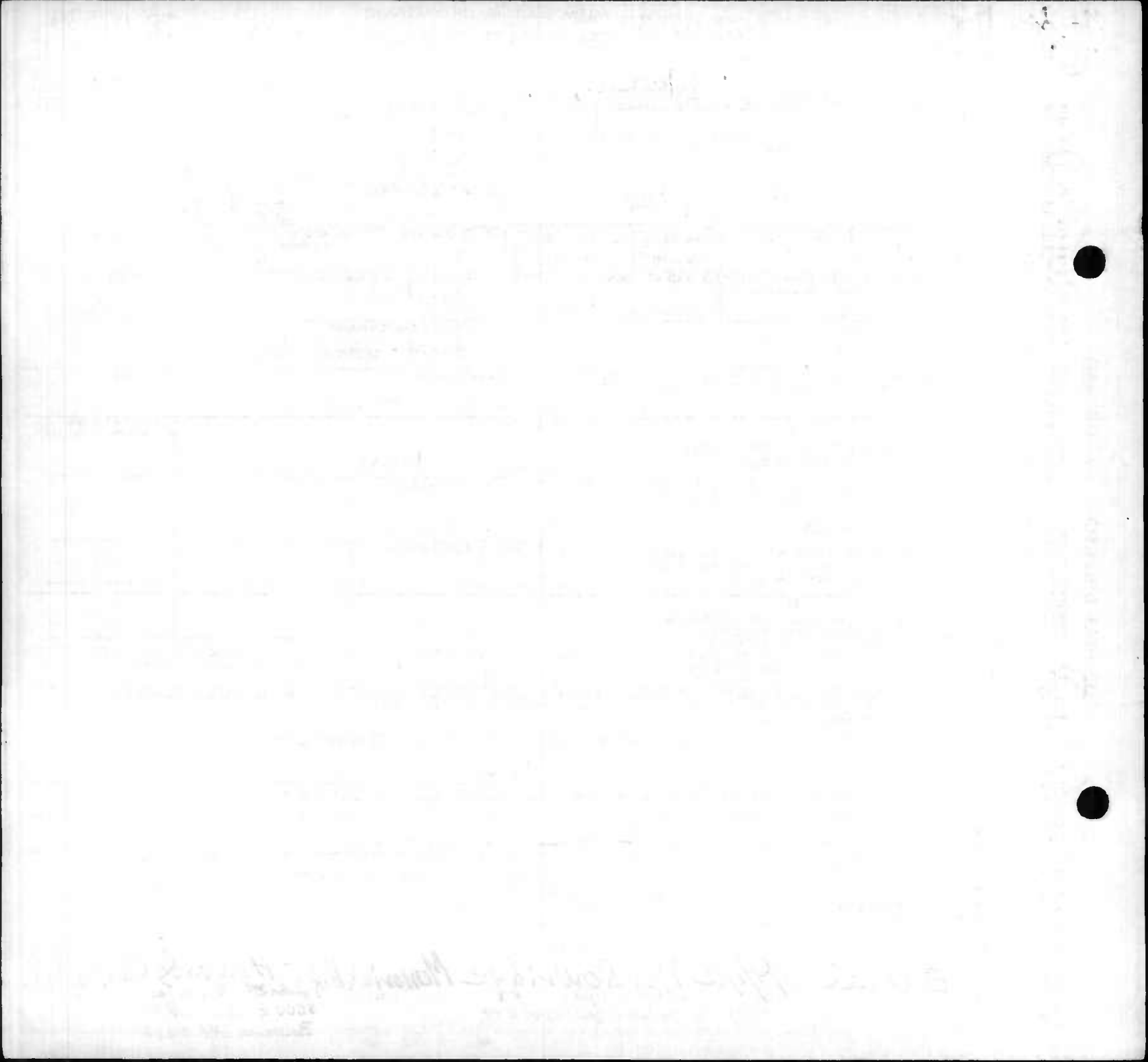
202. 10/11/68

* 10/11 - 10/11/68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 07539				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07539	
72 07539				STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print) <u>Joseph S. Mulcahy, Jr.</u>				2. DATE AND HOUR OF DEATH <u>8/4/72</u> <u>3:12 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Md. General Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>903</u>			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>646 E. 37th St.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/1/11</u>		9. AGE (In years last birthday) <u>61</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>General Motors</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph S. Mulcahy</u>				14. MOTHER'S MAIDEN NAME <u>Susie Irene Cotton</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-05-2409</u>		17. INFORMANT <u>Chart</u>		ADDRESS	
18. I <u>1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Multiple metastases</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Lung cancer</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Multiple metastases</u> (B) <u>Lung cancer</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (A) (this hospital) attended the deceased from <u>August 3</u> 19 <u>72</u> to <u>August 4</u> 19 <u>72</u> that (I) <u>we</u> last saw the deceased alive on <u>August 4</u> 19 <u>72</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) <u>did not</u> view the body after death.							
23A. SIGNATURE <u>James H. Biddison, MD</u>				23B. DATE SIGNED <u>8/4/72</u>		23C. ADDRESS <u>Md. General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/8/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial Park - Howard County, MD</u>		24D. LOCATION (City, town, or county) (State) <u>Howard County, MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1972</u>		25B. NAME OF REGISTRAR <u>Sydney H. Weston</u>		25C. FUNERAL DIRECTOR <u>3000 E. Baltimore St. Baltimore, MD 21284</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 07540 CERTIFICATE OF DEATH				REG. NO. 72 07540 STATE OF MARYLAND-DHMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) KODLEK Mr. JOHN (or) KOLER		2. DATE AND HOUR OF DEATH 8/7/72 1 9/38 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 702		
FULL NAME OF HOSPITAL OR INSTITUTION Church Home and Hospital 35			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 3-26-98		9. AGE (In years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BETH STEEL CO		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13. FATHER'S NAME John Kodlek			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-07-0338		17. INFORMANT MARGARET ZECHMAN 1217 HALSTEAD RD 21234	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Terminal CA of the lung. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/26/72 19 72 to 8/7/72 19 72 that (I) (we) first saw the deceased alive on 8/7/72 19 72 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Pharmacia MD DEGREE				23B. DATE SIGNED 8/7/72	
23C. PHYSICIAN'S NAME (Type) Dr. FELDMAN MD DEGREE				23D. ADDRESS CHURCH HOME & HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE AUG 9 1972		24C. NAME OF CEMETERY or CREMATORY MORELAND MEMORIAL PARK	
24D. LOCATION (City, town, or county) (State) BALTO, MD		25A. DATE REC'D BY HEALTH DEPT. AUG 8 1972			
25B. NAME OF REGISTRAR Dr. J. H. Horton		25C. FUNERAL DIRECTOR DIPPE & BROS INC 7110 BELAIR ROAD			

FUNERAL DIRECTOR: IMPORTANT

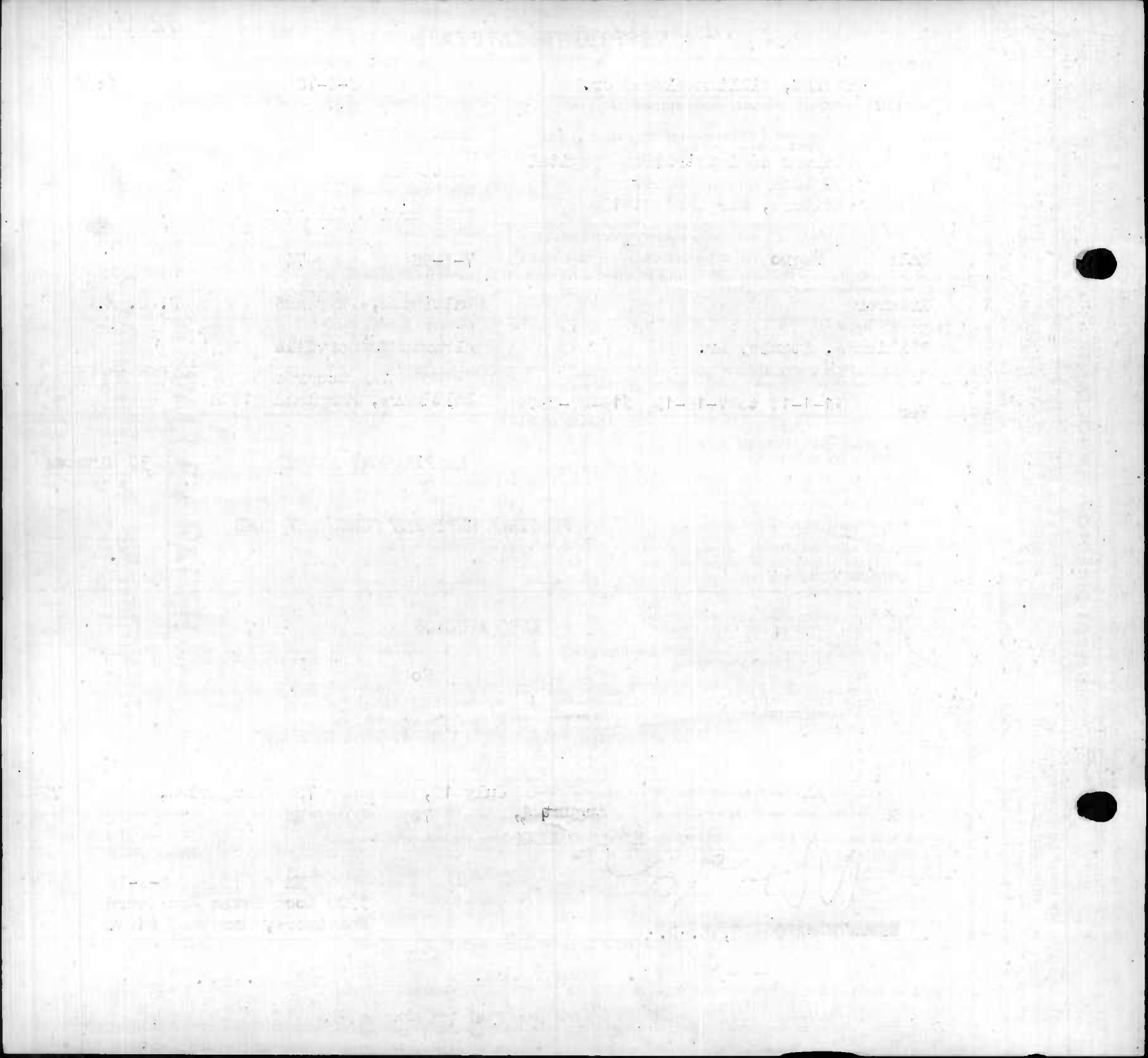
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 07541 CERTIFICATE OF DEATH				REG. NO. 72 07541 STATE OF MARYLAND-DHMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MM Martha White		2. DATE AND HOUR OF DEATH Aug. 6, 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Midtown Home 808 St. Paul St.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 1504		
5. SEX F 6. RACE B 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			8. DATE OF BIRTH 12-16-95 9. AGE (In years last birthday) 76		11. BIRTHPLACE (State or foreign country) MD.
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service			16. SOCIAL SECURITY NO. 214 56 7854		17. INFORMANT Lucille Fisher ADDRESS Same
18. CAUSE OF DEATH					
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cordine Arter	
				(B) Hypertensive Heart Vascular DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis	
				(C) Arteriosclerosis	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/21 19 71 to 8/5 19 72 that (I) (we) last saw the deceased alive on 7/28 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph S. Blum		23B. DATE SIGNED 8/7/72		23C. PHYSICIAN'S NAME (Type) SEPH S. BLUM MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-11-72		24C. NAME OF CEMETERY or CREMATORY MT Zion Cem.	
24D. LOCATION (City, town, or county) BALTO. MD.		24E. STATE (State) MD.		25A. DATE REC'D BY HEALTH DEPT. AUG 8 1972	
25B. NAME OF REGISTRAR Sandra Winston		25C. FUNERAL DIRECTOR V. BAYLEY		25D. ADDRESS 1348 Calhoun St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

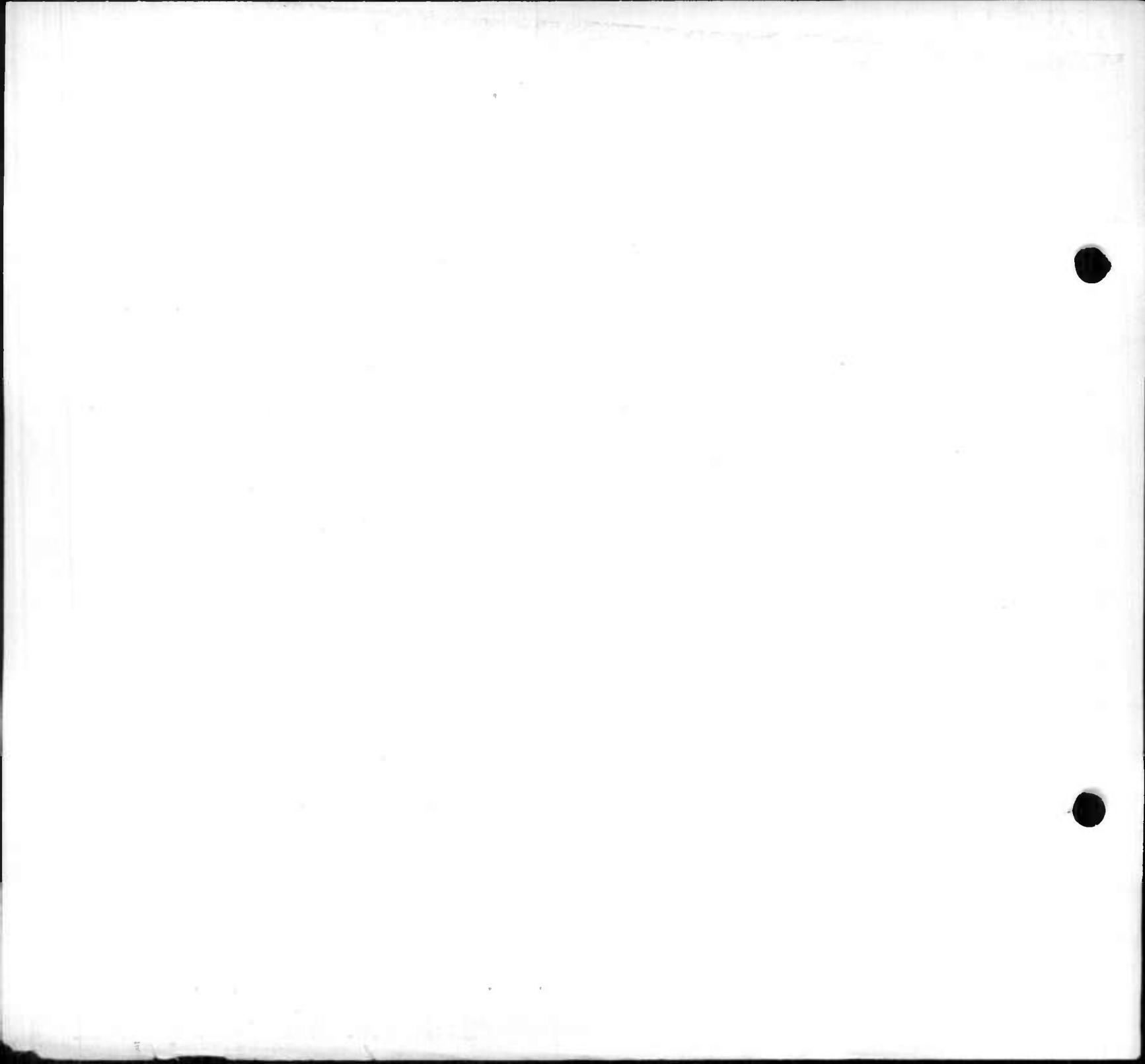
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 07542</u>
72 07542				STATE OF MARYLAND-DHMH
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>STANLEY, William Alfred Jr.</u>		8-4-72 2:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>		A. STATE <u>Maryland</u> B. COUNTY <u>1403</u>		
5. SEX <u>Male</u>		6. RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>7-4-98</u>		9. AGE (In years last birthday) <u>74</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>William A. Stanley Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Alberta Summerville</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes 11-1-17 to 7-19-19</u>		16. SOCIAL SECURITY NO. <u>219-07-8972</u>		17. INFORMANT <u>VAH Records 2224 Druid Hill Ave. Baltimore, Maryland 21218</u>
18. <u>492X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>RESPIRATORY ARREST</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>POSSIBLE RUPTURED PULMONARY BLEB</u> <u>LUNG ABSCESS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>		
MEDICAL CERTIFICATION				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>LUNG ABSCESS</u>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <u>XI</u> (this hospital) attended the deceased from <u>July 10,</u> 19 <u>72</u> to <u>August 4,</u> 19 <u>72</u> , that <u>II</u> (we) last saw the deceased alive on <u>August 4,</u> 19 <u>72</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>II</u> (We) (did) <u>(did not)</u> view the body after death.				
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>8-4-72</u>		23C. PHYSICIAN'S NAME (Type) <u>KENNETH MARGOLIS, M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-8-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>
24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1972</u>		
25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>V. Bailey</u> ADDRESS <u>1348 Calhoun Street</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

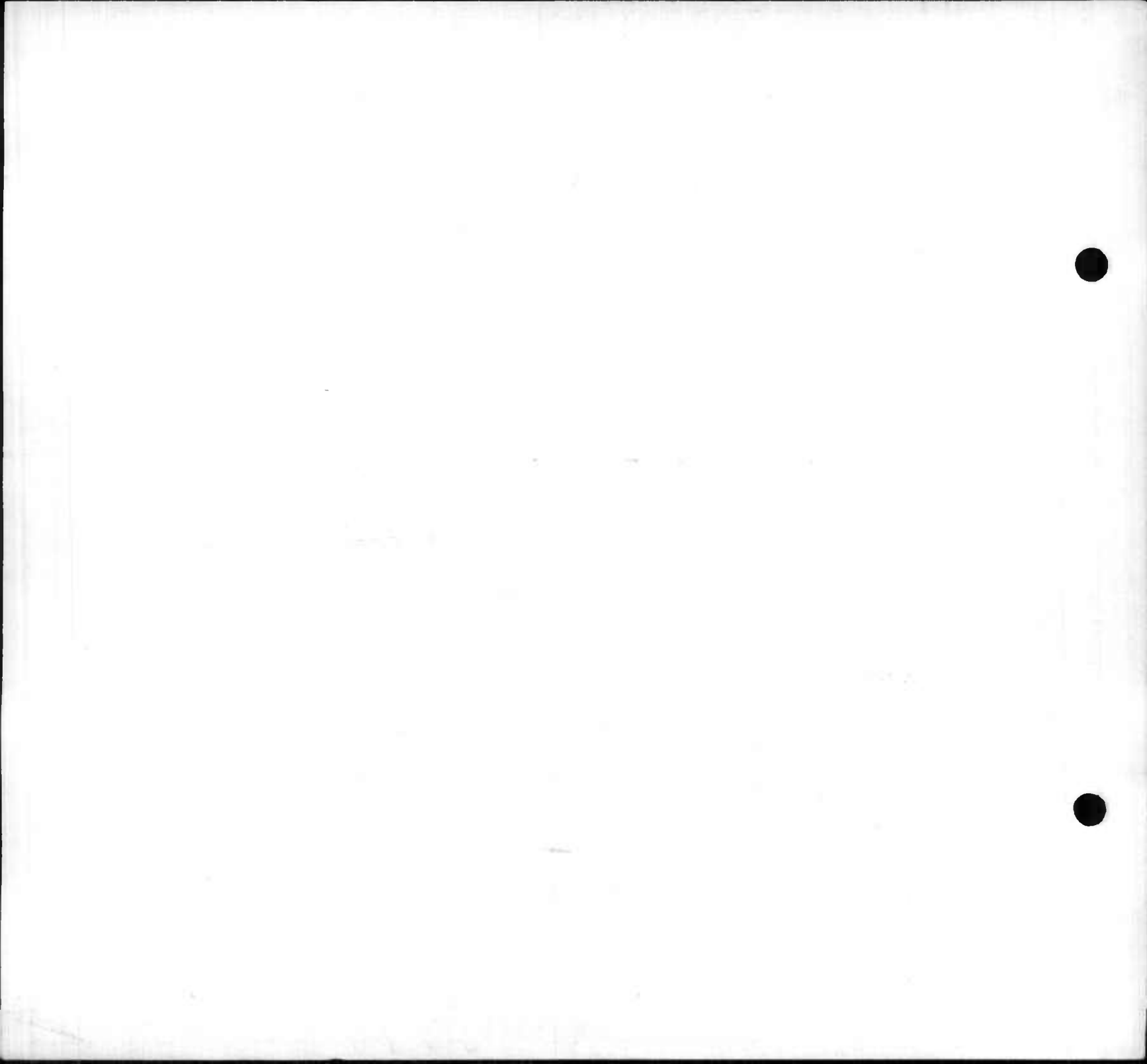
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 07543</u>	
72 07543 CERTIFICATE OF DEATH					
STATE OF MARYLAND-DHMH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>ALBERT HOWARD Sr.</u>		2. DATE AND HOUR OF DEATH <u>8-6-72 12.25 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1602</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>LUTHERAN HOSPITAL OF MARYLAND, BALTIMORE,</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>916, N. PARISH STREET</u>		
5. SEX <u>MALE</u>	6. RACE <u>NE GRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-9-06</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13. FATHER'S NAME <u>Wm. Howard</u>			14. MOTHER'S MAIDEN NAME <u>Mary Farrow</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215019016A</u>		17. INFORMANT <u>Albert Howard</u> ADDRESS <u>3001 Westwood Ave.</u>	
18. <u>162.1 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>NOT KNOWN.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CARCINOMA RIGHT BRONCHUS ABOUT ONE YEAR.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>—</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>8-3-72</u> to <u>8-6-72</u> that <u>(H)</u> (we) last saw the deceased alive on <u>8-6-72</u> and that <u>(H)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>			23B. DATE SIGNED <u>8-7-1972</u>		
23C. PHYSICIAN'S NAME (Type) <u>DR. M. AFTAB AKIWAR MD</u>			23D. ADDRESS <u>730 ASHBURTON STREET BALTIMORE 21216</u>		
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-10-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Carver Mem. Pk.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>V. Bailey</u> ADDRESS <u>1348 Calhoun Street</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 67544</u> STATE OF MARYLAND-DEHE	
BIRTH NO. <u>72 67544</u>		1. NAME OF DECEASED (Type or Print) <u>Wimbush, Bernice</u>		2. DATE AND HOUR OF DEATH <u>8/6/72</u> <u>5:00</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hosp. of Baltimore</u> <u>42</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balt. City</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1518 Traction St. #17</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-3-38</u>	9. AGE (In years last birthday) <u>34</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George A. Henson</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Crowner</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212360536</u>	17. INFORMANT <u>Dunbar Dunby-513 Radnor Wayne Henson (brother)</u>		ADDRESS <u>2435 Woodbrook Ave Balt. Md.</u>
18. <u>1</u> <u>POX I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Terminal Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>pulmonary metastasis</u> (B) <u>Carcinoma of Cervix</u> (Squamous cell) DUE TO, OR AS A CONSEQUENCE OF: <u>—</u> (C) <u>—</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>6 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>—</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>—</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>—</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that <u>he</u> (this hospital) attended the deceased from <u>7/25</u> 19 <u>72</u> to <u>8/6</u> 19 <u>72</u> that (I) <u>he</u> last saw the deceased alive on <u>8/5</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>he</u> (did) <u>not</u> view the body after death.					
23A. SIGNATURE <u>Marc L. Chaiken M.D.</u>			23B. DATE SIGNED <u>8/6/72</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>Marc L. Chaiken M.D.</u>			23D. ADDRESS <u>Sinai Hosp. of Balt.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>8-9-72</u>	24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1972</u>		25B. NAME OF REGISTRAR <u>Gidney Johnston</u>		25C. FUNERAL DIRECTOR <u>V. Bailey</u> ADDRESS <u>1348 Calhoun Street</u>	



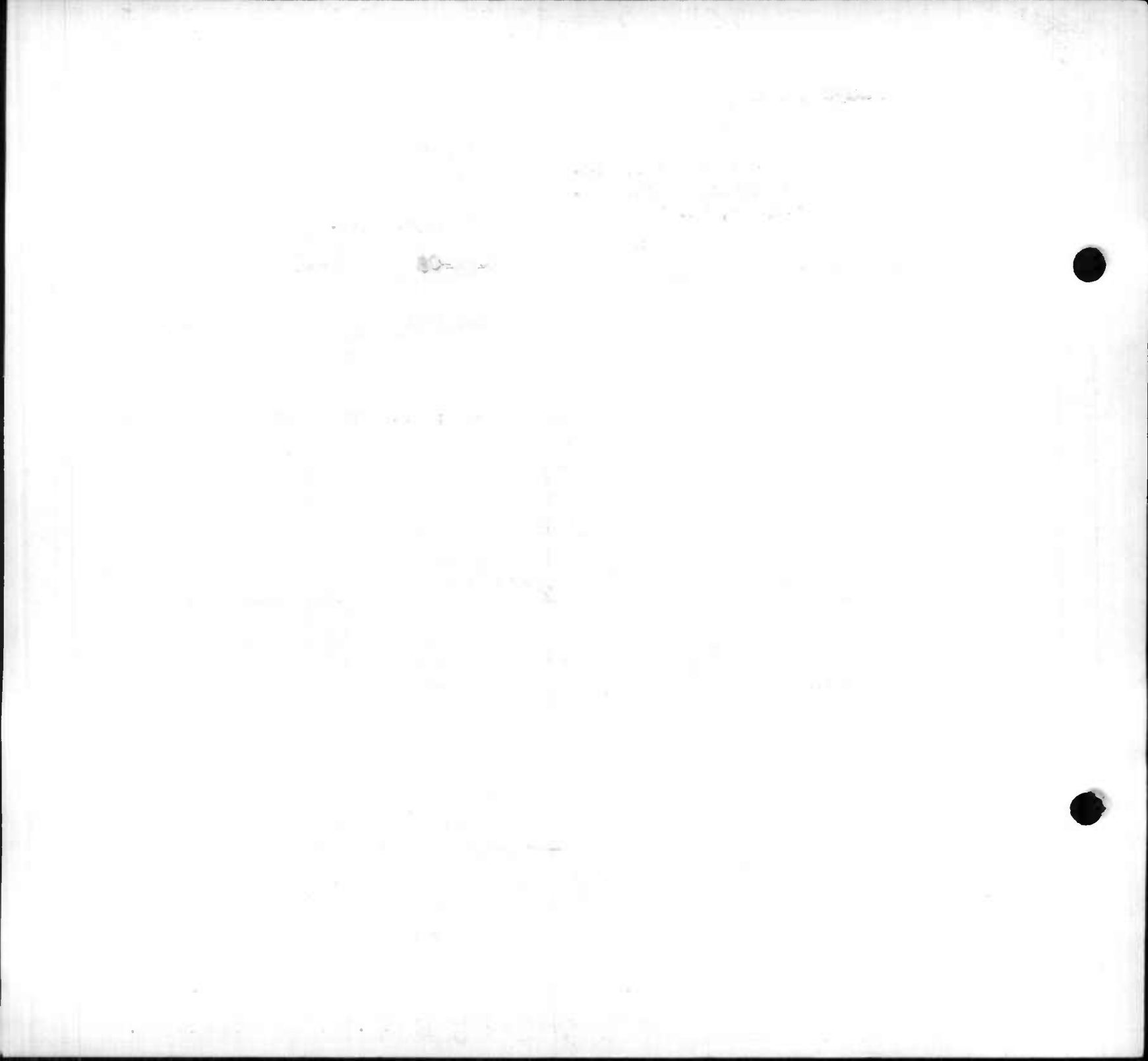
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07545 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 07545
STATE OF MARYLAND-DEMH

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Gladys Gilstrap		2. DATE AND HOUR OF DEATH 8-7-72 7:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland 8. COUNTY 1504	
FULL NAME OF HOSPITAL OR INSTITUTION 39		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc. 2600 Liberty Height Ave. Baltimore, Md. 21215		C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2108 Bryant Ave.	
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-22-08	9. AGE (in years last birthday) 63
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph Thomas		14. MOTHER'S MAIDEN NAME Rebecca		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216365357		17. INFORMANT Julius Gilstrap (HUSBAND) Same As above	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. possible Abdominal Aneurysm Cholelithiasis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Cholelithiasis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown Unknown unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-13 19 72 to 8-7 19 72 that (I) (we) last saw the deceased alive on 8-7 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Aurora C. Tan, M.D.				23B. DATE SIGNED 8-7-72	
23C. PHYSICIAN'S NAME (Type) AURORA C. TAN, M.D.				23D. ADDRESS Provident Hospital, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-10-72		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1972		25B. NAME OF REGISTRAR Andrew W. Houston		25C. FUNERAL DIRECTOR V. Bailey	
				ADDRESS 1348 Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

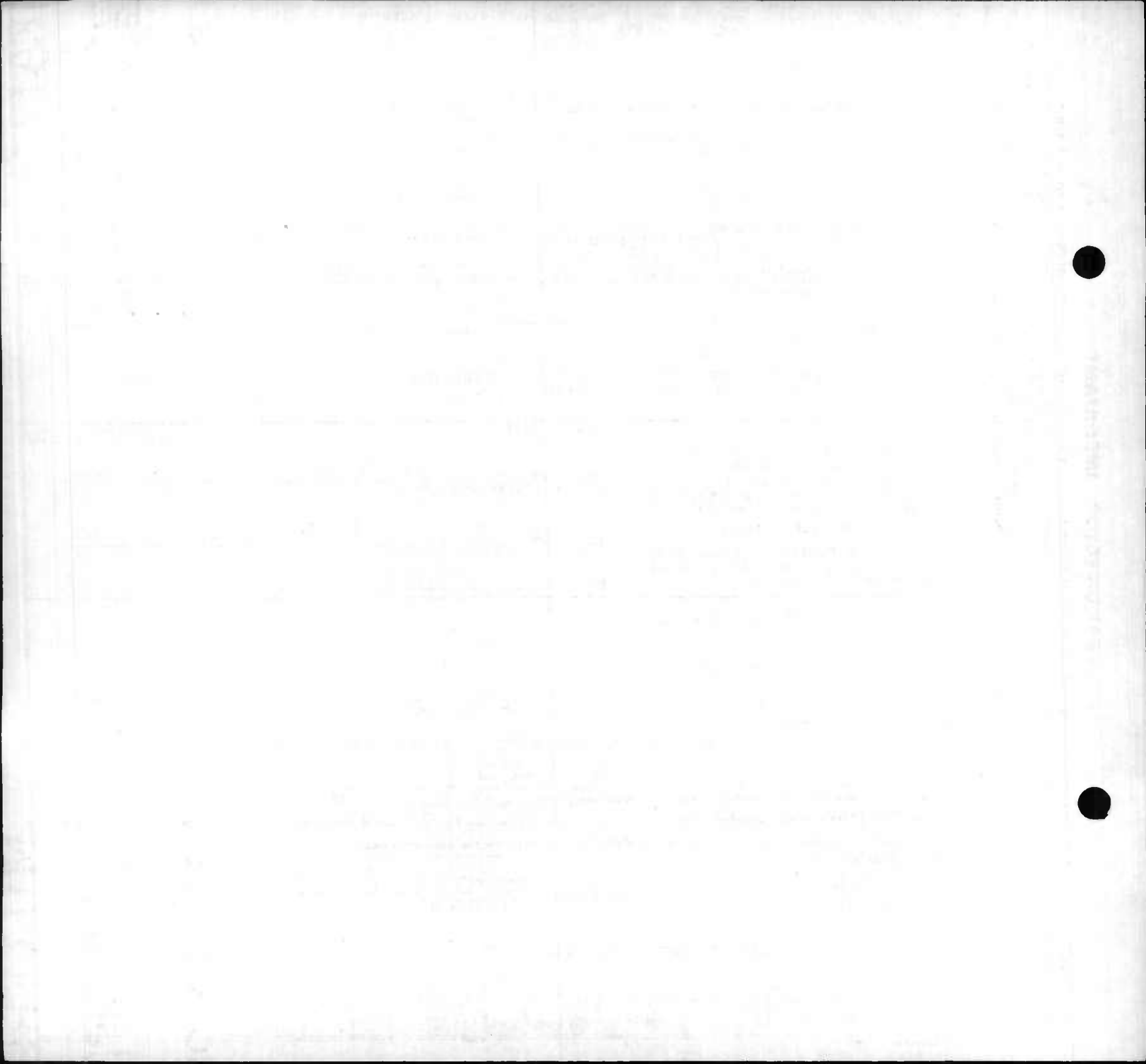
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. 72 07546 REG. NO. 72 07546 STATE OF MARYLAND-DEPT

1. NAME OF DECEASED (Type or Print) <u>Cecilia V. Sewell</u>		2. DATE AND HOUR OF DEATH <u>8-4-72</u> <u>7</u> <u>P.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>37</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Mercy</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1604</u>	
5. SEX <u>F</u> 6. RACE <u>Negroid</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-14-14</u> 9. AGE (in years last birthday) <u>57</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anton Seuzier</u>		14. MOTHER'S MAIDEN NAME <u>Mary Collins</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Frank Sewell -Husband</u>		ADDRESS same	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute Myocardial Infarction</u> <u>Ischemic heart disease</u> <u>Diabetic Mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2h</u> <u>years</u> <u>years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>7/28</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/28</u> 19 <u>72</u> to <u>8/4</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/4</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date end hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>John OHE</u> M.D. DEGREE		23B. DATE SIGNED <u>8/5/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>John Ohe</u> M.D. DEGREE		23D. ADDRESS <u>Mercy Hospital, Baltimore, MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-9-72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 8 1972</u>		25B. NAME OF REGISTRAR <u>John F. Nelson</u>	
25C. FUNERAL DIRECTOR <u>V. Bailey</u>		ADDRESS <u>1348 Calhoun Street</u>	

VS 150-REV. 1/1/68



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 07547
 STATE OF MARYLAND-DHMH

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ORA B. MACZOROWSKI		2. DATE AND HOUR OF DEATH 8/7/72		8/15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Md. B. COUNTY BALTO.			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSP. 4940 Eastern Avenue, Baltimore, Md. 21224				C. CITY OR TOWN BERKSHIRE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 7509 LANGE ST. #21224							
5. SEX Female	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-25-15		9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME SAMUEL WILSON				14. MOTHER'S MAIDEN NAME DOROTHY STEVENS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 225-20-6845		17. INFORMANT Records: BCH-4940 Eastern Ave 21224			
18. 7-27-72 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CARDIO-PULMONARY ARREST 3 days ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (b) DUE TO, OR AS A CONSEQUENCE OF: (c)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from MAY 3 1972 to AUG 7 1972 that (X) (we) last saw the deceased alive on AUG 7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Mark A. Lipton M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/15/72	
23C. PHYSICIAN'S NAME (Type) MARK A. LIPTON M.D.				23D. ADDRESS 4940 Eastern Ave. Baltimore, Md. 21224 BALTO. CITY HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-9-72		24C. NAME of CEMETERY or CREMATORY MT. CARMEL CEM.		24D. LOCATION (City, town, or county) (State) 5712 O'DONNELL ST. BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1972		25B. NAME OF REGISTRAR Sidney J. ...		25C. FUNERAL DIRECTOR 6224 EASTERN AVE. BALTO., MD.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-220				72 07548		BALTIMORE CITY HEALTH DEPARTMENT		72 07548	
BIRTH NO.				72 07548		REG. NO.		72 07548	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		STATE OF MARYLAND, DISTRICT OF COLUMBIA			
BACKUS Mrs. PEARL				8/6/72		14-35 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE B. COUNTY		102			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL 35				IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F				6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/31/1890	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10B. KIND OF BUSINESS OR INDUSTRY Housewife		9. AGE (In years last birthday) 82		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? MARYLAND				13. FATHER'S NAME WILLIAM LANGFORD		14. MOTHER'S MAIDEN NAME DORA ROTE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 911-19-1767				17. INFORMANT CHARLES V. BACKUS		ADDRESS 723 S. POTOMAC STREET, BALTIMORE, MD.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Infarction				19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Terminal CMA ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Fracture left Hip				21A. DATE OF OPERATION 6/7/72		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURED Hip		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 620 S. Ellwood Ave.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) Home		21C. WHERE DID INJURY OCCUR? 620 S. Ellwood Ave.		21D. TIME OF INJURY (APPROX.) 5-27-72 2 PM	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>				21F. HOW DID INJURY OCCUR? Fell while mopping floor		22. I certify that (I) (this hospital) attended the deceased from 5/27/72 to 8/6/72 and that (I) (we) lost saw the deceased alive on 8/6/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE R. S. Smith M.D. DEGREE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) Dr. WONG			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8/9/72		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 8 1972				25B. NAME OF REGISTRAR Audrey W. Boston		25C. FUNERAL DIRECTOR Nicholas T. Matthews			
25D. ADDRESS 3031 Eastern Ave., Baltimore, Md.				25E. ADDRESS		25F. ADDRESS			

Carroll I-formation

ASCD

Function left leg

110

630 2. Ellwood

X Fall white waggly line

2-27-22

X

Carroll I-formation

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07549

BIRTH NO. 71-18677

STATE OF MARYLAND-DHMH

1. NAME OF DECEASED (Type or Print) LIONEL FOOTE		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 8 3 1972 2:45a	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 3 1972 2:45a	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1538	
9. DATE OF BIRTH 11/04/71		10. AGE (In years last birthday) 8	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edwin Foote		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Jean Heigh		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Jean Heigh	
19. CAUSE OF DEATH E8841X Pulmonary Edema & Hemorrhage		ADDRESS 3605 Liberty Ave.	

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) E8841X		CAUSE OF DEATH Pulmonary Edema & Hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) Cerebral Edema DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Balto. City - 3605 Liberty Heights Ave.	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) Aug. 2, 1972-8:00 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Fall from bed	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Marvin S. Platt		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		Marvin S. Platt, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8/06/72		24C. NAME of CEMETERY or CREMATORY St. Johns Chr. Cem.	
24D. LOCATION (City, town, or county) (State) Calvert Co., Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 8 1972		25B. NAME OF REGISTRAR Sidney H. Hinton	
25C. FUNERAL DIRECTOR Frederick E. Sewell		ADDRESS Frederick E. Sewell		DATE SIGNED 8-3-72	

8-31-1972 - Completion of cause of death on a pending medical examiner death certificate
Marvin S. Platt, M.D.

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 07550				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07550			
STATE OF MARYLAND-DMH				CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <i>Josephine O'Konski</i>				2. DATE AND HOUR OF DEATH <i>August 2, 1972</i>				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>43 South Baltimore General Hospital</i>				A. STATE <i>Baltimore</i>				B. COUNTY <i>2401</i>			
				C. CITY OR TOWN <i>Maryland</i>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <i>1544 LaTrobe Park Terrace</i>							
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11/6/86</i>		9. AGE (in years last birthday) <i>85</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>				11. BIRTHPLACE (State or foreign country) <i>Poland</i>			
12. CITIZEN OF WHAT COUNTRY? <i>Poland</i>				13. FATHER'S NAME <i>Peter Mackiewicz</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>212-09-59460</i>				17. INFORMANT <i>Cecelia Daley</i> ADDRESS <i>1544 LaTrobe Park Terrace</i>			
18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH <i>Anteromedullary Cord Vascular Disease</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i>			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Anemia, severe</i>				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>months</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <i>Osteoarthritis</i>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>June</i> 1971 to <i>August 2</i> 1972, that (I) (we) last saw the deceased alive on <i>August 2</i> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Blendo V. Igoe, M.D.</i>				23B. DATE SIGNED <i>8-4-72</i>							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>8/5/72</i>				24C. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cemetery</i>			
24D. LOCATION (City, town, or county) (State) <i>Anne Arundel, Maryland</i>											
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 8 1972</i>				25B. NAME OF REGISTRAR <i>Anthony Horton</i>				25C. FUNERAL DIRECTOR <i>Charles L. Stevens Funeral Home, Inc.</i> ADDRESS <i>1500 East Ford Avenue</i>			

B-650

72 07551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 07551

BIRTH NO. STATE OF MARYLAND - DHMH

1. NAME OF DECEASED

(Type or Print)

BRYAN, MARY

2. DATE AND HOUR OF DEATH

Aug 7

10³⁰ A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

The Good Samaritan Hospital
45

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2116 E Hoffman St

5. SEX

F

6. RACE

Black

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

01-05-06

9. AGE (In years last birthday)

66

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Same address

12. CITIZEN OF WHAT COUNTRY?

American

13. FATHER'S NAME

Oliver Robinson

14. MOTHER'S MAIDEN NAME

Martha Russell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

217 12 3360

17. INFORMANT

Clarence Bryan 2116 Hoffman St

ADDRESS

18. 157.91

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Cancer of Pancreas

8 months

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

16-22-72

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

gandice

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Aug 7 1972 to Aug 7 1972 and that (I) (we) last saw the deceased alive on Aug 7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Teh-ching Wang

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

Aug 8 '72

23C. PHYSICIAN'S NAME (Type)

TEH-CHING WANG MD

23D. ADDRESS

4818 TRUESDALE Ave
Baltimore MD 21206

24A. BURIAL - CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-12-72

24C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Pk.

24D. LOCATION (City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 9 1972

25B. NAME OF REGISTRAR

Audrey Whitton

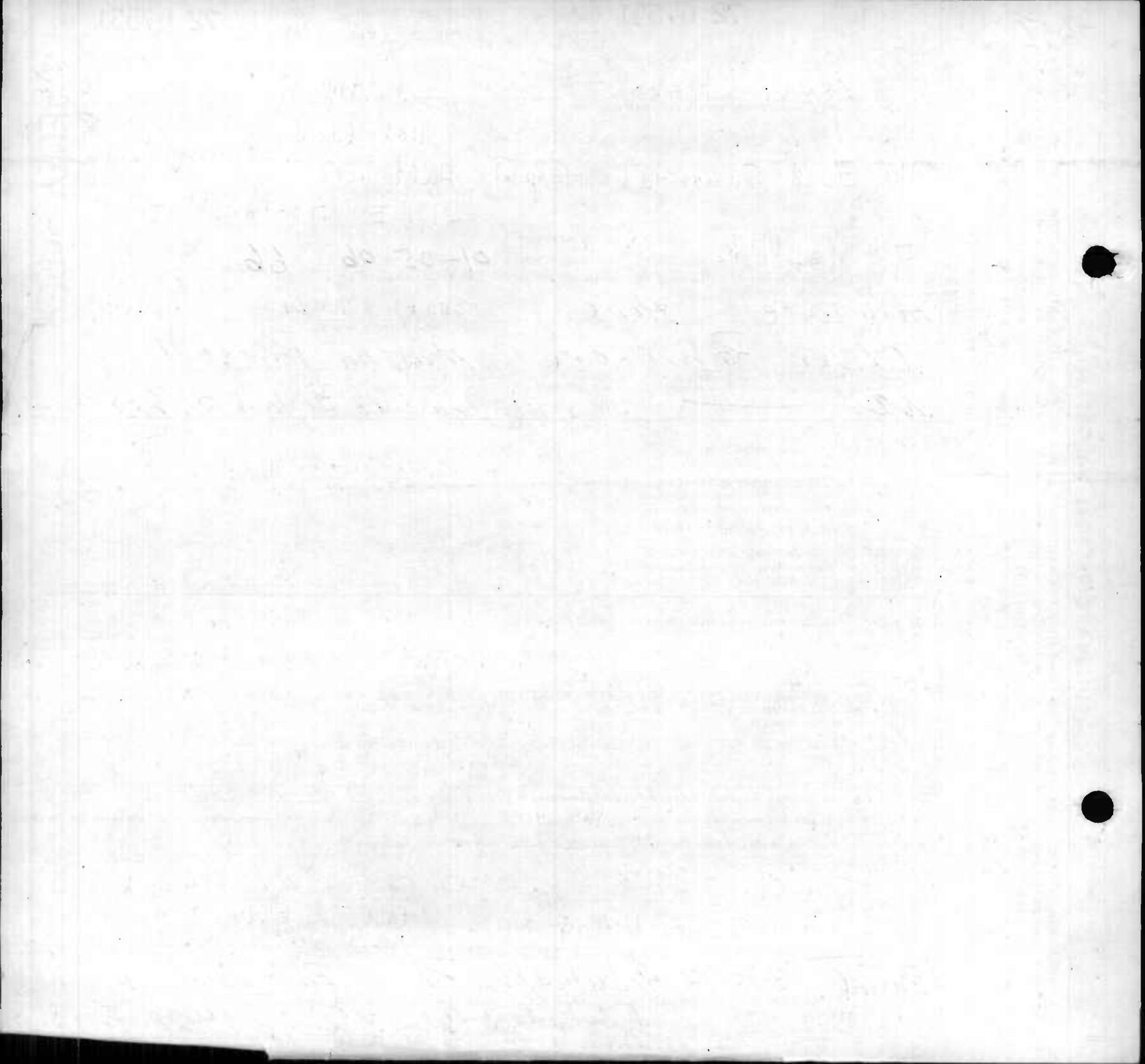
25C. FUNERAL DIRECTOR

Calvin B. Scruggs 1412 E. Pratt

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07552

BIRTH NO.

1. NAME OF DECEASED

(Type or Print) EDWARD JOHNSON

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL (If not in hospital or institution, give street
OR INSTITUTION ADDRESS OR LOCATION)

33 JOHNS HOPKINS HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

August 6, 1972

1:29 A.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

802

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

12/27/33

10. AGE (In years
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1941 N. Collington Avenue

11. BIRTHPLACE (State or foreign country)

Balto. Md

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Jerome Johnson

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Contractor

14B. KIND OF BUSINESS OR INDUSTRY

F & S Contractor

15. MOTHER'S MAIDEN NAME

Sarah Baker

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

218-28-7989

18. INFORMANT

Sarah Johnson

ADDRESS

3023 E Federal St.

19.

E9651X

CAUSE OF DEATH

Gunshot wound of head

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Sidewalk

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2135 E. North Avenue

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) August 6, 1972 1:15
A.M.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot during altercation

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/6/72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/10/72

24C. NAME OF CEMETERY or CREMATORY

Balto. Cem.

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 9 1972

25B. NAME OF REGISTRAR

Andrew W. Houston

25C. FUNERAL DIRECTOR

Joseph J. Locke Jr.

ADDRESS

1304 N. Central Ave

2500 ST

1000 ST

1000 ST

1000 ST

1000 ST

1000 ST

1000 ST

1000 ST

1000 ST

1000 ST

1000 ST

1
R-420

72 07553 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DHMH

REG. NO. 72 07553

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RUDOLPH ROLES

2. DATE OF DEATH Known ☐ Estimated ☐ Month Day Year Hour M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 JOHNS HOPKINS HOSPITAL

3. DATE PRONOUNCED DEAD Month Day Year Hour M.
August 4, 1972 10:42 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY 1547

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

March 25 1933

10. AGE (In years last birthday)

39

11. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

2709 Gwynns Falls Parkway

11. BIRTHPLACE (State or foreign country)

Baltr. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Albert Handy

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Hospital-Aide

14B. KIND OF BUSINESS OR INDUSTRY

N. Charles Hosp.

15. MOTHER'S MAIDEN NAME

Thelma Roles

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes Korean War

17. SOCIAL SECURITY NO.

218-28-9038

18. INFORMANT

Beverly Allen

ADDRESS

4901 Lock Raven Blvd.

19. E966X

CAUSE OF DEATH

Stab wound of chest

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Bar (Federal Lounge) 2304 E. Federal Street

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)

8-4-72 10:30 P. M.

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Stabbed during altercation

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

Deputy CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/5/72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/9/72

24C. NAME OF CEMETERY or CREMATORY

Baltr. Cem.

24D. LOCATION (City, town, or county) (State)

Baltr. Md.

25A. DATE REC'D BY HEALTH DEPT.

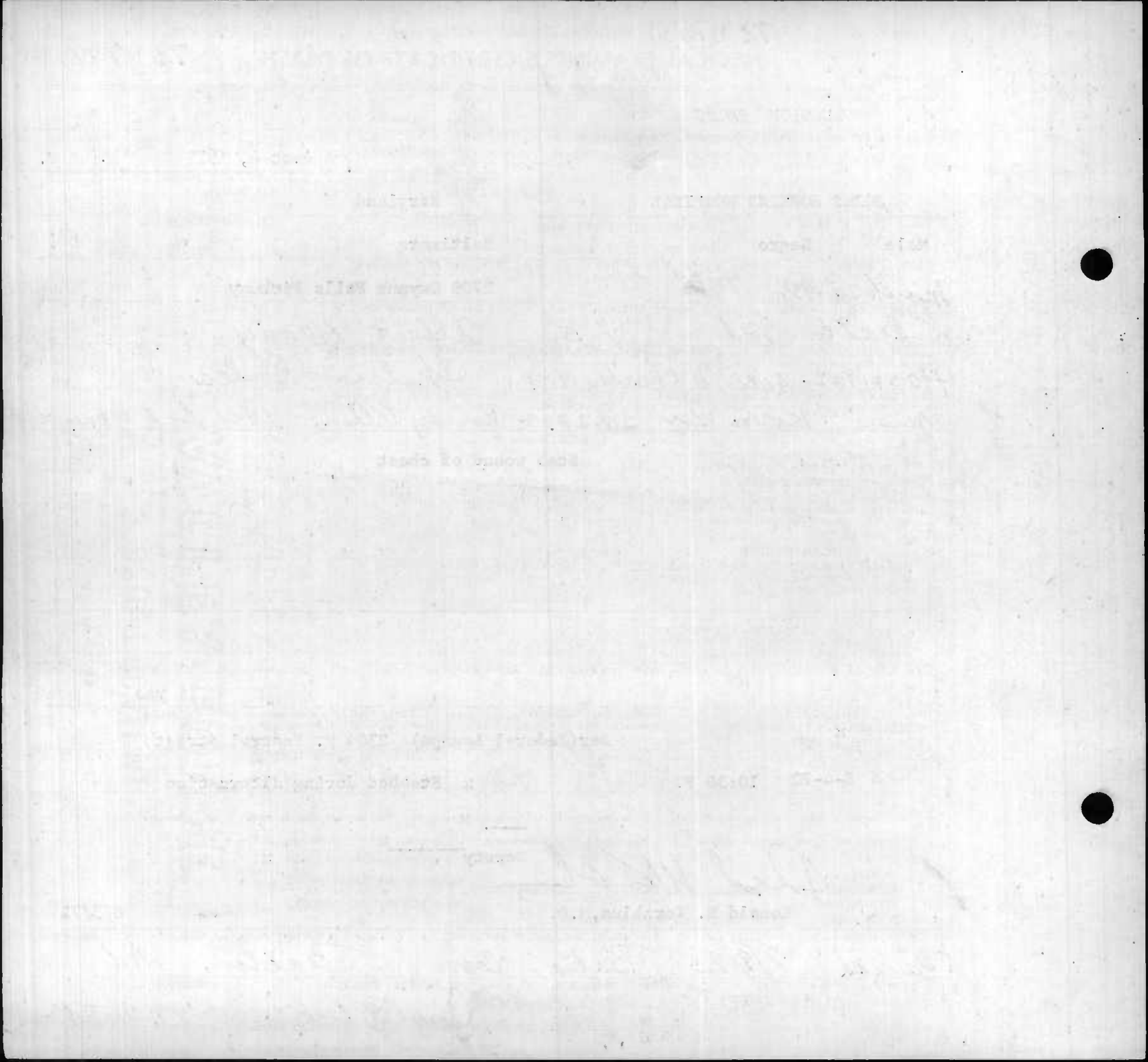
AUG 9 1972

25B. NAME OF REGISTRAR

Sidney H. Hinton

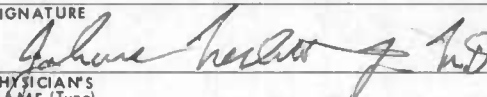
25C. FUNERAL DIRECTOR

Joseph H. Locke Jr. 1304 N. Central Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07554 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07554	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Paul F. Due		8/7/72 10 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 516 Nottingham Road			A. STATE Md B. COUNTY 2854		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 516 Nottingham Road		
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/17/1896	9. AGE (In years last birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Late John C. Due		14. MOTHER'S MAIDEN NAME Late Amanda Fromm	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO. 217-38-0056		17. INFORMANT Mrs. Olive Due, 516 Nottingham Road 21229	
18. 433.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebro thrombosis (B) Arteriosclerotic cerebral vascular disease (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks. 3 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 2 1972 to Aug 7 1972, that (I) (we) last saw the deceased alive on Aug. 7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 8-8-72	
23C. PHYSICIAN'S NAME (Type) Dr. John A. Nesbitt				23D. ADDRESS 1009 Frederick Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/11/72		24C. NAME OF CEMETERY or CREMATORY Druid Ridge	
24D. LOCATION (City, town, or county) (State) Pikesville, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972		25B. NAME OF REGISTRAR Sidney Witzke	
25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue		25D. ADDRESS			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

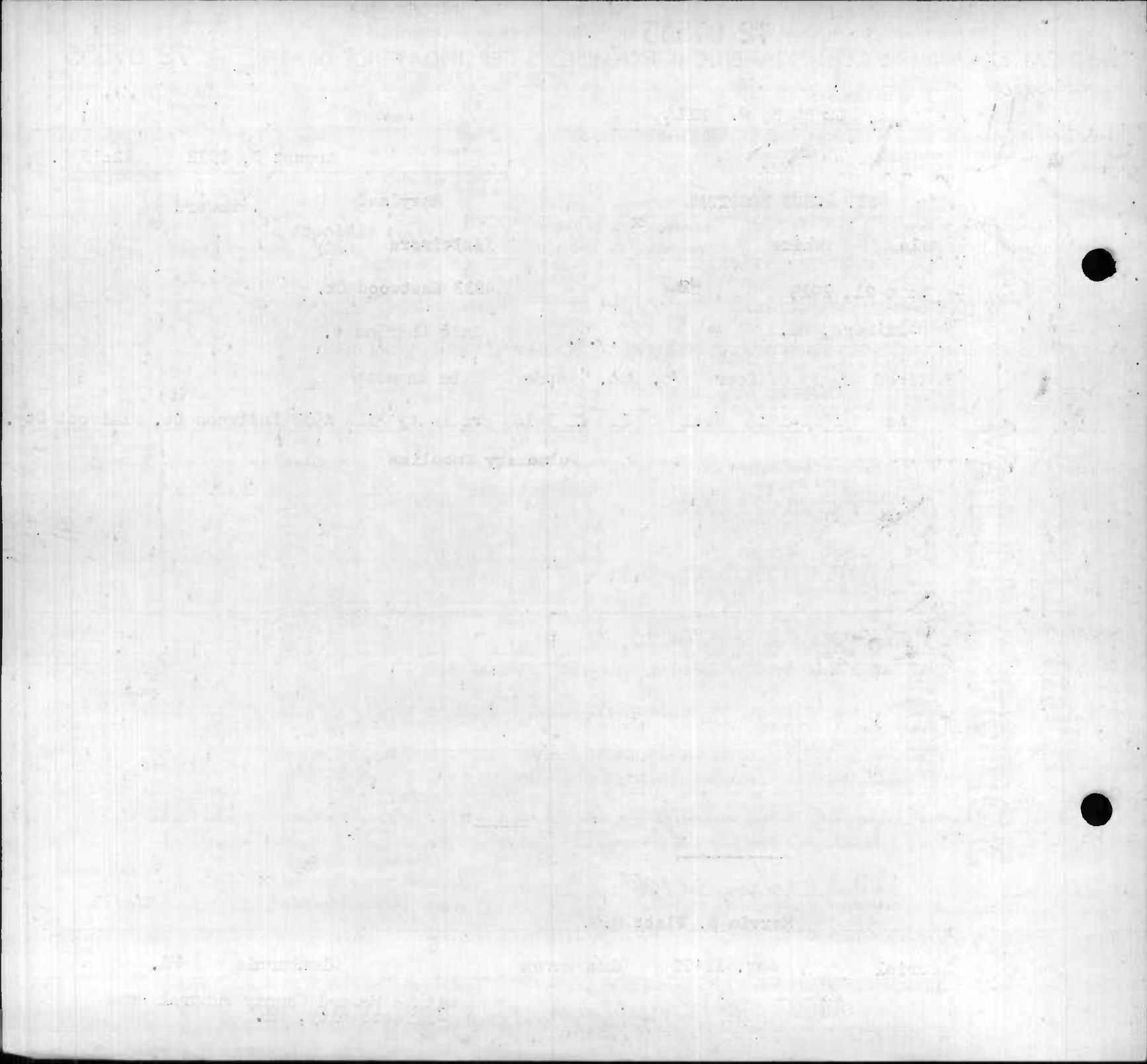
REG. NO.

72 07555

BIRTH NO.

STATE OF MARYLAND-DHMH

1. NAME OF DECEASED (Type or Print) CHARLES W. HILL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour August 7, 1972 12:15 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Ellicott City	
9. DATE OF BIRTH Sept 21, 1919		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10. AGE (In years last birthday) 52		E. STREET AND NUMBER 4933 Eastwood Ct.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME late Charles C.		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supply Officer Ft. Geo. Meade	
15. MOTHER'S MAIDEN NAME late Annette		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1941-1946 WWII	
17. SOCIAL SECURITY NO. 219 DL 3614		18. INFORMANT Mrs Patsy Hill	
19. 450X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. DATE SIGNED 8/8/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 11 '72	
24C. NAME of CEMETERY or CREMATORY Glen Haven		24D. LOCATION (City, town, or county) (State) Glenburnie Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972		25B. NAME OF REGISTRAR Sidney Johnston	
25C. FUNERAL DIRECTOR Witzke Howard County Funeral Home		ADDRESS Ellicott City, Md.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

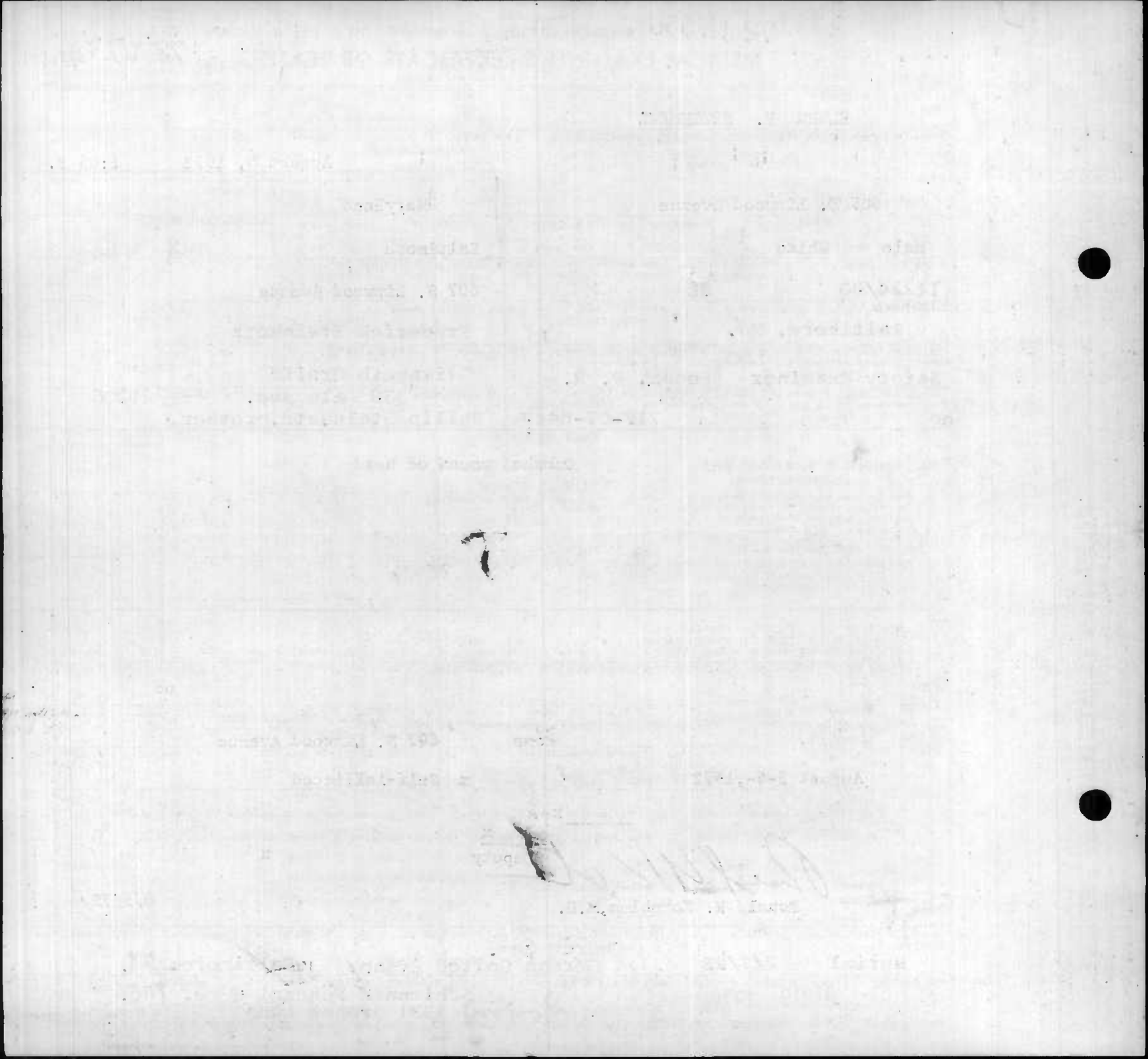
72 07556

BIRTH NO.

STATE OF MARYLAND-DEMH

REG. NO.

1. NAME OF DECEASED (Type or Print) ELMER F. STEINMETZ		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 607 S. Linwood Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour M. August 4, 1972 1:05 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 11/24/90		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 81		E. STREET AND NUMBER 607 S. Linwood Avenue	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? Frederick Steinmetz	
13. FATHER'S NAME Frederick Steinmetz		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Safety Examiner	
15. MOTHER'S MAIDEN NAME Elizabeth Greiff		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 717-07-8449		18. INFORMANT 538 Dale Ave. Philip Steinmetz, brother,	
19. E 9554 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID INJURY OCCUR? 607 S. Linwood Avenue		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) August 3-4-, 1972 ? m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Self-inflicted	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. DATE SIGNED 8/5/72 EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/72	
24C. NAME OF CEMETERY or CREMATORY Church Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972		25B. NAME OF REGISTRAR Adrian J. Heston	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07557

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM MALKOWSKI		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 4 UNION MEMORIAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour August 5, 1972 1:40 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH March 5, 1912		10. AGE (In years last birthday) 60	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Seaman		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Gertrude Golembieski		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 218-05-1832		18. INFORMANT (Sister) 904 ADDRESS S. Curley St. Baltimore, Maryland	
19. E 987X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Craniocerebral Injuries DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 1		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 7-9-72 9:33 A.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2642 Maryland Avenue		22F. HOW DID INJURY OCCUR? Jumped from 2nd floor window	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/6/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/72	
24C. NAME OF CEMETERY or CREMATORY Sacred Heart of Mary Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972		25B. NAME OF REGISTRAR Sidney H. Horkow	
25C. FUNERAL DIRECTOR John J. Duda, 2829 Hudson St. Balto. Md.		ADDRESS	

TO THE HONORABLE SENATE
OF THE UNITED STATES

REPORT
OF THE
COMMISSIONER OF THE GENERAL LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
MAY 1, 1890

ALBANY:
JAMES B. LEECH, PRINTER.
1891.

THE
GENERAL LAND OFFICE
WASHINGTON, D. C.

ALBANY:
JAMES B. LEECH, PRINTER.
1891.

THE
GENERAL LAND OFFICE
WASHINGTON, D. C.

ALBANY:
JAMES B. LEECH, PRINTER.
1891.

THE
GENERAL LAND OFFICE
WASHINGTON, D. C.

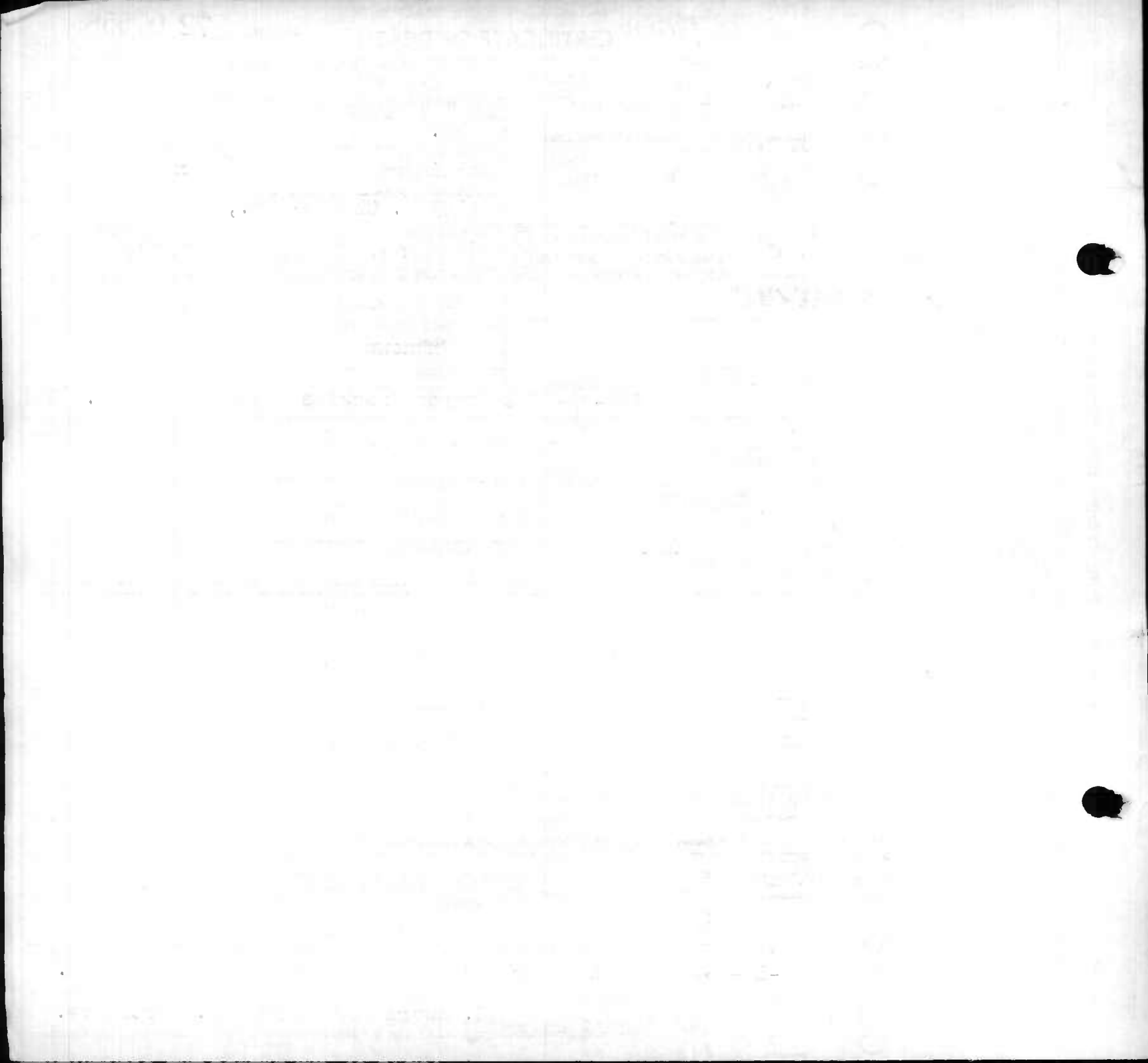
ALBANY:
JAMES B. LEECH, PRINTER.
1891.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07558

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHREG. NO. 72 07558
STATE OF MARYLAND-DHMH

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>CLARENCE W. UNGER</u>		2. DATE AND HOUR OF DEATH <u>8/6/1972</u> <u>3.00 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1206</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL.</u> <u>44</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>11/27/1891</u>		9. AGE (In years last birthday) <u>80</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Salesman</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-03-5502</u>	
17. INFORMANT <u>Warren Brackins</u>		ADDRESS <u>727 Crosby Rd. (28)</u>		18. <u>4/12.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CARDIAC ARRYTHMIA.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ARTERIOSCLEROTIC HEART DISEASE</u>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>URINARY TRACT INFECTION, BENIGN PROSTATIC HIPERTROPHY. BENN. CYSTS.</u>		19. DATE OF OPERATION <u>0</u>	
20. AUTOPSY? (Yes or No) <u>No</u>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>	
23. DATE OF OPERATION <u>0</u>		24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		25. TIME OF INJURY (Approx.) <u>None</u>	
26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		27. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		28. HOW DID INJURY OCCUR? <u>None</u>	
29. I certify that (I) (this hospital) attended the deceased from <u>07/13/1972</u> 19 <u> </u> to <u>08/6/72</u> 19 <u> </u>		30. that (I) (we) last saw the deceased alive on <u>8/6/72</u> 19 <u> </u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		31. DATE SIGNED <u>8/6/72</u>	
32. SIGNATURE <u>Hermann Wendorff</u>		33. PHYSICIAN'S NAME (Type) <u>HERMANN WENDORFF</u>		34. ADDRESS <u>UNION MEMORIAL HOSPITAL.</u>	
35. DATE REC'D. BY HEALTH DEPT. <u>AUG 9 1972</u>		36. NAME OF REGISTRAR <u>Sidney J. [Signature]</u>		37. FUNERAL DIRECTOR <u>G. Howard Strong</u>	
38. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		39. DATE <u>8-10-1972</u>		40. LOCATION (City, town, or county) <u>Baltimore</u>	
41. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		42. STATE <u>Md.</u>		43. ADDRESS <u>3207 W. North Ave.,</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07559		72 07559	
72 07559				CERTIFICATE OF DEATH		STATE OF MARYLAND	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				FRANCES TUNIS		AUGUST 5, 1972 4 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 3315 BONNIE ROAD 00				A. STATE MARYLAND			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3315 BONNIE ROAD #21208			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-2-1901	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY RETAIL	11. BIRTHPLACE (State or foreign country) VIENNA, AUSTRIA		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME SIMON POLIAKOFF			14. MOTHER'S MAIDEN NAME ESTHER GOTTLIEB				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-32-0643A	17. INFORMANT ADDRESS MISS ANITA TUNIS, 3315 BONNIE ROAD #21208				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory failure metastatic carcinoma of liver (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 1 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1961 to Aug 5, 1972, that (I) (we) last saw the deceased alive on Aug 4, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph R. Myerowitz M.D.				23B. DATE SIGNED Aug 5, 1972		23C. PHYSICIAN'S NAME (Type) JOSEPH R. MYEROWITZ	
23D. ADDRESS 6615 REISTERSTOWN ROAD				23E. FUNERAL DIRECTOR ADDRESS SQL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/6/72		24C. NAME OF CEMETERY or CREMATORY SHAAREI ZION		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972		25B. NAME OF REGISTRAR Gentry Johnston		25C. FUNERAL DIRECTOR ADDRESS SQL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

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JAN 10 1961
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DHMH

REG. NO. 72 07560

BIRTH NO.

1. NAME OF DECEASED

(Type or Print) MARY DOBB

2. DATE

Known ☐ Month Day YearEstimated ☐

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2709 Hanson Street, terrace apt.

3. DATE

Month Day Year

PRONOUNCED DEAD August 4, 1972

Hour 9:35 P.

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

2740

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

12/28/09

10. AGE (In years last birthday)

62

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

2709 Hanson Street

11. BIRTH PLACE (State or foreign country)

BALTIMORE, MD

12. CITIZEN OF

WHAT COUNTRY? USA

13. FATHER'S NAME

ISAAC RODMAN

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

AT HOME

15. MOTHER'S MAIDEN NAME

ETTA

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

28-36-3951

18. INFORMANT

ADDRESS

Joseph DOBB - 817 JUDY LANE 2108

19. E950.3

CAUSE OF DEATH

Overdose of chloral hydrate

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

2709 Hanson Street

27-40

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

8-4-1972

Unk. m.

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Ingested chloral hydrate

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/5/72

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8/6/72

24C. NAME of CEMETERY or CREMATORY

Hebrew Young Men

24D. LOCATION (City, town, or county) (State)

WINDSOR MILL RD

25A. DATE REC'D BY HEALTH DEPT.

AUG 9 1972

25B. NAME OF REGISTRAR

Sidney Winston

25C. FUNERAL DIRECTOR

SOL LEVINSON & BROS Rest Rd

ADDRESS

8-15-1972 - Completion of cause of death on a pending medical examiner death
certificate - Ronald N. Kornblum, M.D. HRS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07561

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
 STATE OF MARYLAND-DHMH

REG. NO.

72 07561

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Pomerance, Aaron

2. DATE AND HOUR OF DEATH

8-4-72

7:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

5829 Park Heights Avenue

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1-5-1911

9. AGE (In years last birthday)

60 61

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SELF EMPLOYED

10B. KIND OF BUSINESS OR INDUSTRY

GROCERY STORE

11. BIRTHPLACE (State or foreign country)

POLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Pomeranc, Israel

14. MOTHER'S MAIDEN NAME

Shenbalt, Malka

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service

NO

16. SOCIAL SECURITY NO.

218-146-3191

17. INFORMANT

ADDRESS

MRS. ADELE POMERANC, 5829 PARK HEIGHTS AVE. #15

18. 038891

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Cardiac arrest 20 to prolonged

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) Possible sepsis, possible

DUE TO, OR AS A CONSEQUENCE OF:

12 hrs

(C) aspiration pneumonia

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Pneumonia disease

2 years

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Harry R. Jacobson

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

8-4-72

23C. PHYSICIAN'S NAME (Type)

Harry R. Jacobson

23D. ADDRESS

Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8/6/72

24C. NAME OF CEMETERY or CREMATORY

BNAI JACOB

24D. LOCATION

(City, town, or county)

BALTIMORE, MARYLAND

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 9 1972

25B. NAME OF REGISTRAR

Frederick H. Weston

25C. FUNERAL DIRECTOR

SOL LEVINSON, & BROS, 6010 REISTERSTOWN ROAD

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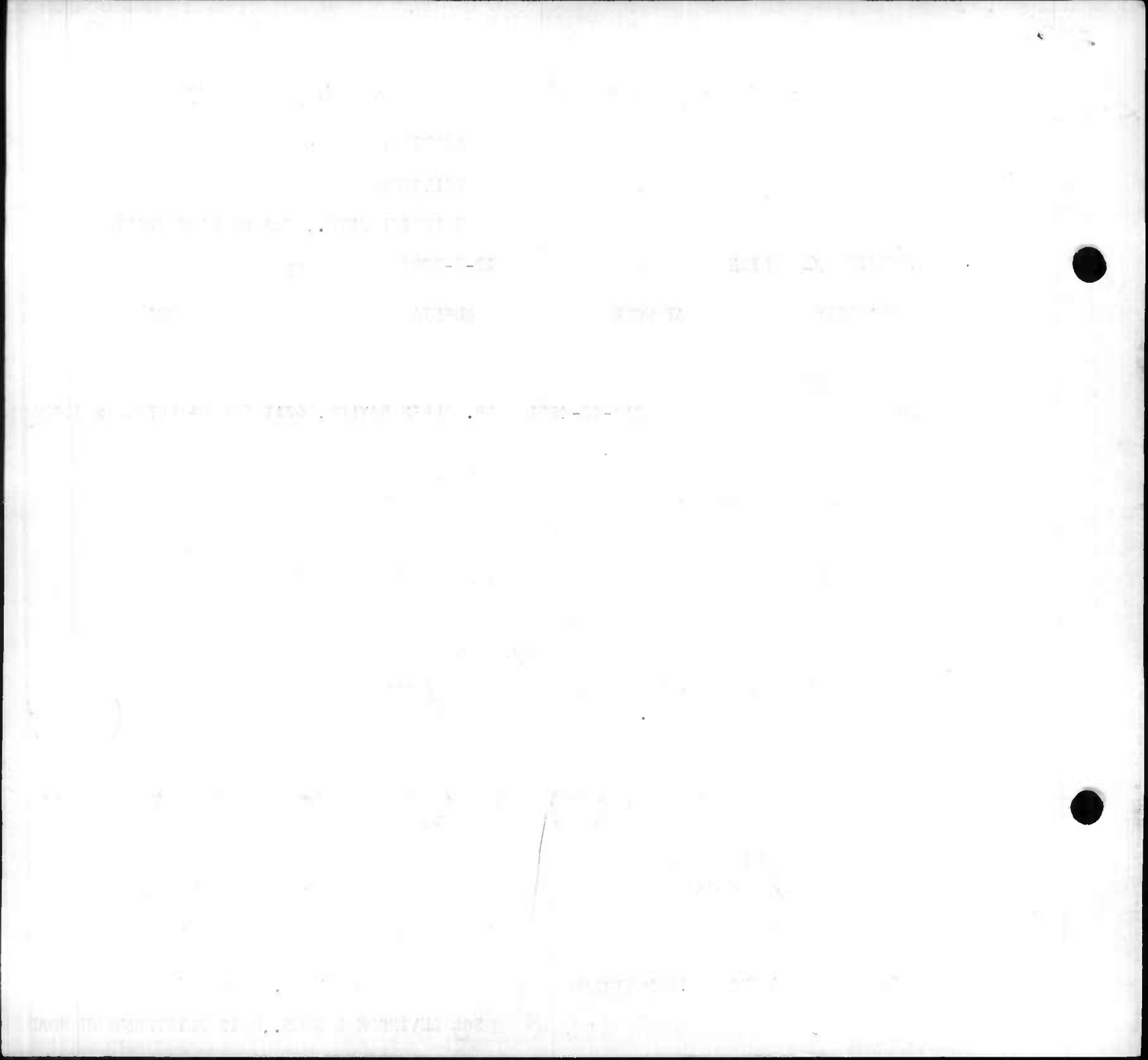
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07562		REG. NO. 72 07562	
CERTIFICATE OF DEATH							
STATE OF MARYLAND-DHMH							
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		BAYLUS, ANNA		4 th August 1972 4 ¹⁰ P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE			
SINGH HOSPITAL OF BALTIMORE INC.,				MARYLAND			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				3601 IMPERIAL APTS., CLARKS LANE #21215			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.	
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12-5-1888	83			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		AT HOME		RUSSIA		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		214-22-4571		DR. ALVIN BAYLUS, 6211 SAREVA DRIVE #2 21209			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				Cerebrovascular Accident			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				Hypertension and			
				(C) Chronic atrial fibrillation			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Congestive Cardiac failure			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
17-18-72		C.I. Bleeding		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7-12-1972 to 8-4-1972 that (I) (we) last saw the deceased alive on 8-4-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Prasad MBBS				8-4-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
P. PRASAD MBBS				Singh Hospital of Baltimore, md 21215			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		8/6/72		BETH TFILOH		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 9 1972		Sidney K. Koston		SOL LEVINSON & BROS.		6010 REISTERSTOWN ROAD	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07563	
1. NAME OF DECEASED (Type or Print) ALFRED XXXXXXXX BLOCH		2. DATE AND HOUR OF DEATH 8/4/72 8:20 P.M.		STATE OF MARYLAND-DEATH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME HOSPITAL. 3.5		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY XXXXXXXXXXXXXXXXXXXX C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER XXXXXXXXXXXXXXXXXXXX 2301 PENTLAND DR. #21234			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8.17.95	9. AGE (In years last birthday) 76	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXXXXXXXXXXXXXX MATHEMATICIAN		10B. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.		11. BIRTHPLACE (State or foreign country) GERMANY	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JULIUS BLOCH		14. MOTHER'S MAIDEN NAME REZHA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. ALICE BLOCH, 2301 PENTLAND DR. #21234	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.91 Acute myocardial infarction		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arterio sclerosis Cardio Vascular Disease & Hypertension & actual fibrillation		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 8.4. 1972 _____ 19____ and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Firozvi		23B. DATE SIGNED 8.4.1972		23C. PHYSICIAN'S NAME (Type) Firozvi	
23D. ADDRESS 100 N. BROADWAY BALTIMORE 21231		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/6/72	
24C. NAME of CEMETERY or CREMATORY CHEVRA AHAVAS CHESSED		24D. LOCATION (City, town, or county) (State) RANDALLSTOWN, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972	
25B. NAME OF REGISTRAR Sol Levinson		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25D. ADDRESS	

7-14-42

RECEIVED

U.S. DEPARTMENT OF JUSTICE

COMMUNICATIONS SECTION

11-11-42

RECEIVED

U.S. DEPARTMENT OF JUSTICE

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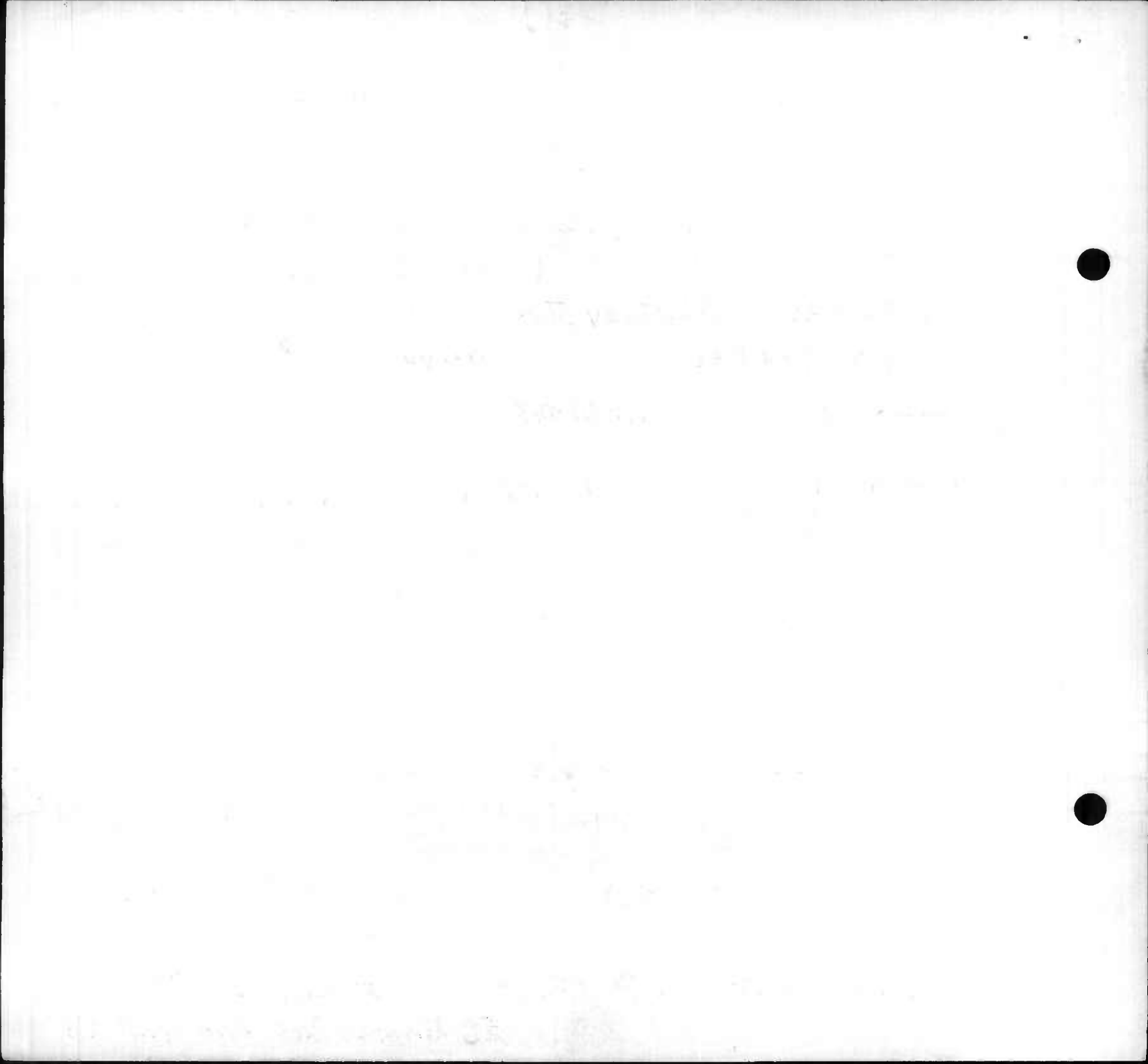
U.S. DEPARTMENT OF JUSTICE

U.S. DEPARTMENT OF JUSTICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 07564 CERTIFICATE OF DEATH				X REG. NO. 72 07564	
STATE OF MARYLAND-DHMH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOSEPH KELLAR		8/5/72 5:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP. BALTO 42			A. STATE Md. B. COUNTY BALTO 5300		
5. SEX MALE 6. RACE CAUC			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			8. DATE OF BIRTH 9. AGE (in years last birthday)		
COUNTER MAN			8/31/12 59		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		
DELICATESSEN STORE			USA ?		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JOHN KELLAR			HANNA ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
NO			216-08-5118		
17. INFORMANT			ADDRESS		
HOSPITAL RECORD					
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				2 weeks	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				RESPIRATORY FAILURE	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) OBSTRUCTIVE LUNG DISEASE	
				(C) HEART DISEASE, ASCUD	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7/31/72 19 to 8/5 19 72 that (I) (we) lost saw the deceased alive on 8/5 19 72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Robert S. London, MD				8/5/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ROBERT S. LONDON				SINAI HOSPITAL BALTO.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		8/6/72		BETH TFILOH	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 9 1972		Society of Friends		Sol REUBEN & Bros 6010 Reist. Rd.	
24D. LOCATION (City, town, or county)		24E. LOCATION (City, town, or county)		24F. LOCATION (City, town, or county)	
BALTO		BALTO		BALTO	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

1. The first part of the report is a general description of the project and its objectives. This section is followed by a detailed description of the methodology used in the study. The third part of the report is a discussion of the results of the study, which are presented in a series of tables and figures. The final part of the report is a conclusion and a list of references.

2. The second part of the report is a detailed description of the methodology used in the study. This section is followed by a discussion of the results of the study, which are presented in a series of tables and figures. The final part of the report is a conclusion and a list of references.

3. The third part of the report is a discussion of the results of the study, which are presented in a series of tables and figures. The final part of the report is a conclusion and a list of references.

4. The final part of the report is a conclusion and a list of references.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07566 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MIRIAM GOODMAN

2. DATE AND HOUR OF DEATH

AUGUST 6, 1972

2 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

TEMPLE GARDEN APTS., APT. 905
2601 MADISON AVENUE

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

BALTIMORE

E. STREET AND NUMBER

TEMPLE GARDEN APTS., APT. 905, 2601 MADISON AVENUE

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

JUNE 4, 1891

9. AGE (In years last birthday)

81

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JACOB BECKELMAN

14. MOTHER'S MAIDEN NAME

RIFKA

?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

212-03-4540

17. INFORMANT

SAMUEL L. SILBER, MD. NATIONAL BANK BLDG. #2

ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Arteriosclerotic Heart Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

15 YRS

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Diabetes Mellitus

15 YRS

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 1957 to Aug 6 1972, that (I) (we) last saw the deceased alive on Aug. 2 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Albert J. Himelfarb

DEGREE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

8/7/72

23C. PHYSICIAN'S NAME (Type)

ALBERT J. HIMELFARB

23D. ADDRESS

222 W. COLD SPRING LANE

DEGREE

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8/7/72

24C. NAME of CEMETERY or CREMATORY

BALTIMORE HEBREW

24D. LOCATION

(City, town, or county)

BALTIMORE, MARYLAND

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 9 1972

25B. NAME OF REGISTRAR

Dr. J. J. H. H. H.

25C. FUNERAL DIRECTOR

SOL LEVINSON & BROS.

ADDRESS

6010 REISTERSTOWN ROAD

WILLIAM D. BENT

WILLIAM D. BENT

WILLIAM D. BENT

WILLIAM D. BENT

WILLIAM D. BENT

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R-200

72 07567 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07567

BIRTH NO.		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) JAMES ROCHE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home & Hosp. (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 6 1972 11:20p M.	
6. SEX male		7. RACE white	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 4/20/1921		10. AGE (In years last birthday) 51	
11. BIRTHPLACE (State or foreign country) Canal Zone		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Roche		14. STREET AND NUMBER 3708 Gibbons Ave.	
15. MOTHER'S MAIDEN NAME Cecilia Blum		16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Armco Steel Co.	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes WW2		18. SOCIAL SECURITY NO. 215-18-8839	
19. CAUSE OF DEATH Severe coronary artery disease		20. INFORMANT Mrs. Dorothy Lee Roche same	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		22. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
25. DATE OF OPERATION 2		26. CONDITION FOR WHICH OPERATION WAS PERFORMED	
27. AUTOPSY? (Yes or No) yes		28. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
31. TIME (Month) (Day) (Year) (Hour) (Approx.)		32. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
33. HOW DID INJURY OCCUR?		34. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
35. ACTUAL SIGNATURE William P. Mulloy, M.D.		36. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
37. DATE SIGNED 8-7-72		38. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
39. 24B. DATE 8/10/72		40. 24C. NAME OF CEMETERY or CREMATORY Moreland Mem.	
41. 24D. LOCATION (City, town, or county) (State) Balto. Md.		42. 25A. DATE REC'D BY HEALTH DEPT. 111G9 1972	
43. 25B. NAME OF REGISTRAR Sidney H. Heston		44. 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07568		REG. NO. 72 07568	
72 07568				STATE OF MARYLAND-DHMH			
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>FREDERICK William Wurst</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <u>8/6/72 @ 12:14 am</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> <u>34</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Balt. Md. 21223</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1850 W. Pratt Street</u> <u>1903</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/28/1881</u>	9. AGE (In years last birthday) <u>91</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shirt Cutter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin Wurst</u>				14. MOTHER'S MAIDEN NAME <u>Alma Bruckner</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-16-4587</u>		17. INFORMANT <u>Mrs. Lillian VanOrden</u>		ADDRESS <u>Same</u>	
18. <u>485X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Bilateral confluent bronchopneumonia</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>days</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>7</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</u> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>8-6-1972</u> to <u>8-7-1972</u> that (I) (we) last saw the deceased alive on <u>8-6-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Octavio A. Ruiz M.D.</u> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/7/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Octavio A. Ruiz M.D.</u> DEGREE				23D. ADDRESS <u>Bon Secours Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/10/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1972</u>		25B. NAME OF REGISTRAR <u>Audrey J. Weston</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. 5305 Harford Rd. 21214</u> ADDRESS			

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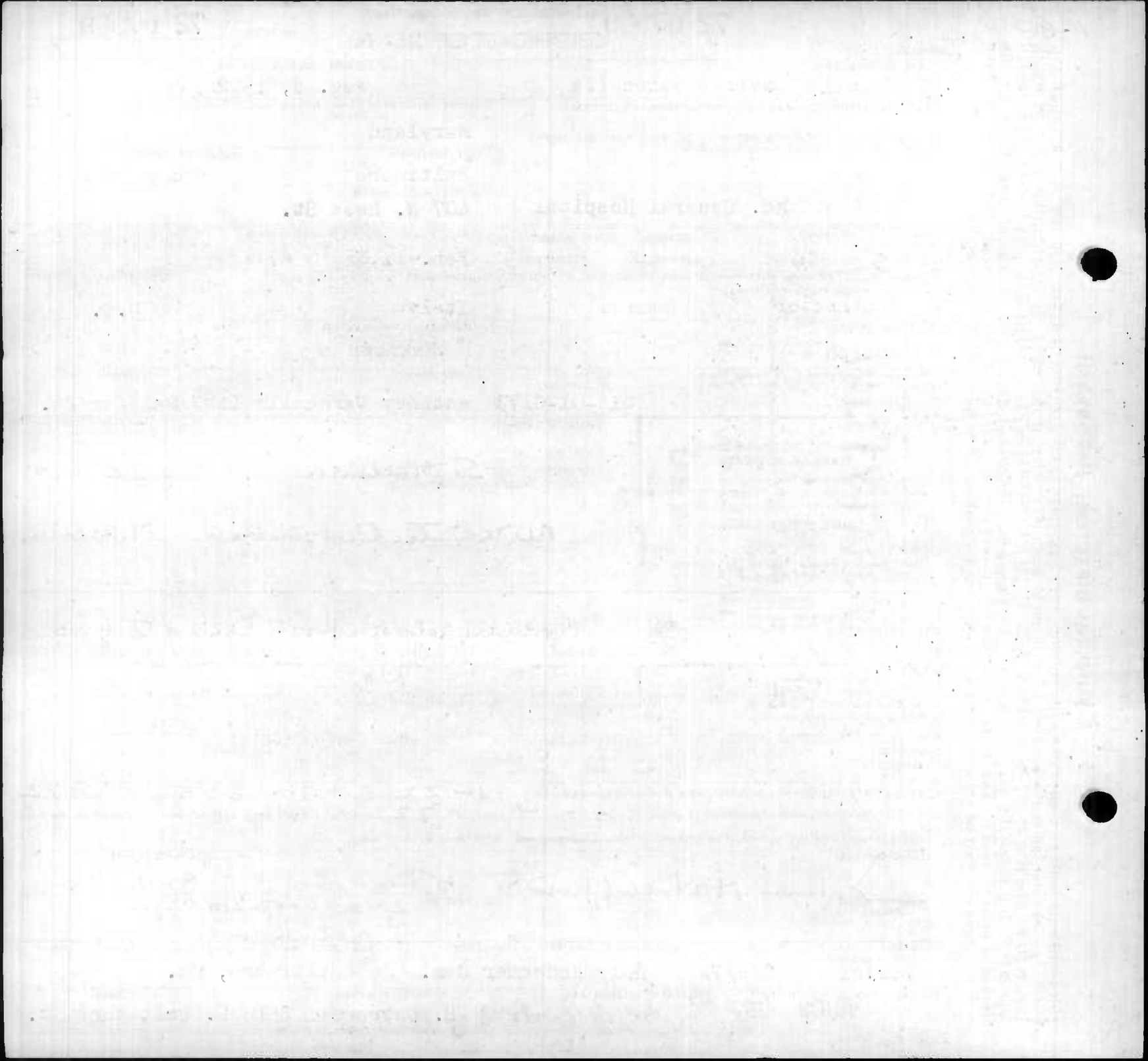
10-10-1944

10-10-1944

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07569 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07569	
STATE OF MARYLAND - DHMH					
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) (Samuel) Saverio Varacalle			
2. DATE AND HOUR OF DEATH Aug. 5, 1972		M. _____			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Md. General Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 602 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 407 N. Rose St.			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 85	9. AGE (In years last birthday) 87	If Under 1 Yr. Months _____ Days _____ If Under 24 Hrs. Hours _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10B. KIND OF BUSINESS OR INDUSTRY Cement		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Joseph			
14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 218-01-8173		17. INFORMANT Anthony Varacalle 4107 Halifax Ct.			
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Sepsis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Sepsis (B) Metastatic Carcinoma (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 4 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerotic Heart Disease		19A. DATE OF OPERATION None			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-22 19 71 to 8-5 19 72 that (I) (we) last saw the deceased alive on 8-4 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James H. H. H.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-7-72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 2430 Chetwood Circle Timonium, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/72		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972			
25B. NAME OF REGISTRAR Anthony Varacalle		25C. FUNERAL DIRECTOR B. Dabrowski 2818 E. Baltimore St.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 07570

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Maurice E. Skinner Jr.

2. DATE AND HOUR OF DEATH

4 Aug 72

5¹⁰ P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Union Memorial Hospital
444 Baltimore 21218

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md.

Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

26 Blythwood Rd.

5. SEX

M

6. RACE

C

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

3-10-01

9. AGE (in years
last birthday)

71

11. Under 1 Yr.
Months: Days: Hours: Min.12. Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Investments

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Maurice E. Skinner

14. MOTHER'S MAIDEN NAME

Nettie Howser

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

215 05 3437A

17. INFORMANT

Mrs. Helen E. Skinner

ADDRESS

Same

18.

440.91

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At

Work ☐

Not While

At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

19

to

Aug 4

1972

that (I) (we) last saw the deceased alive on

19

72

and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

William J. Helgeson MD

Attending

Phys. ☒

Med.

Director ☐

Staff

Phys. ☐

23B. DATE SIGNED

4 Aug 72

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/8/72

24C. NAME OF CEMETERY or CREMATORY

Greenmount Cemetery

24D. LOCATION

(City, town, or county)

(State)

Greenmount Ave Balto

Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 9 1972

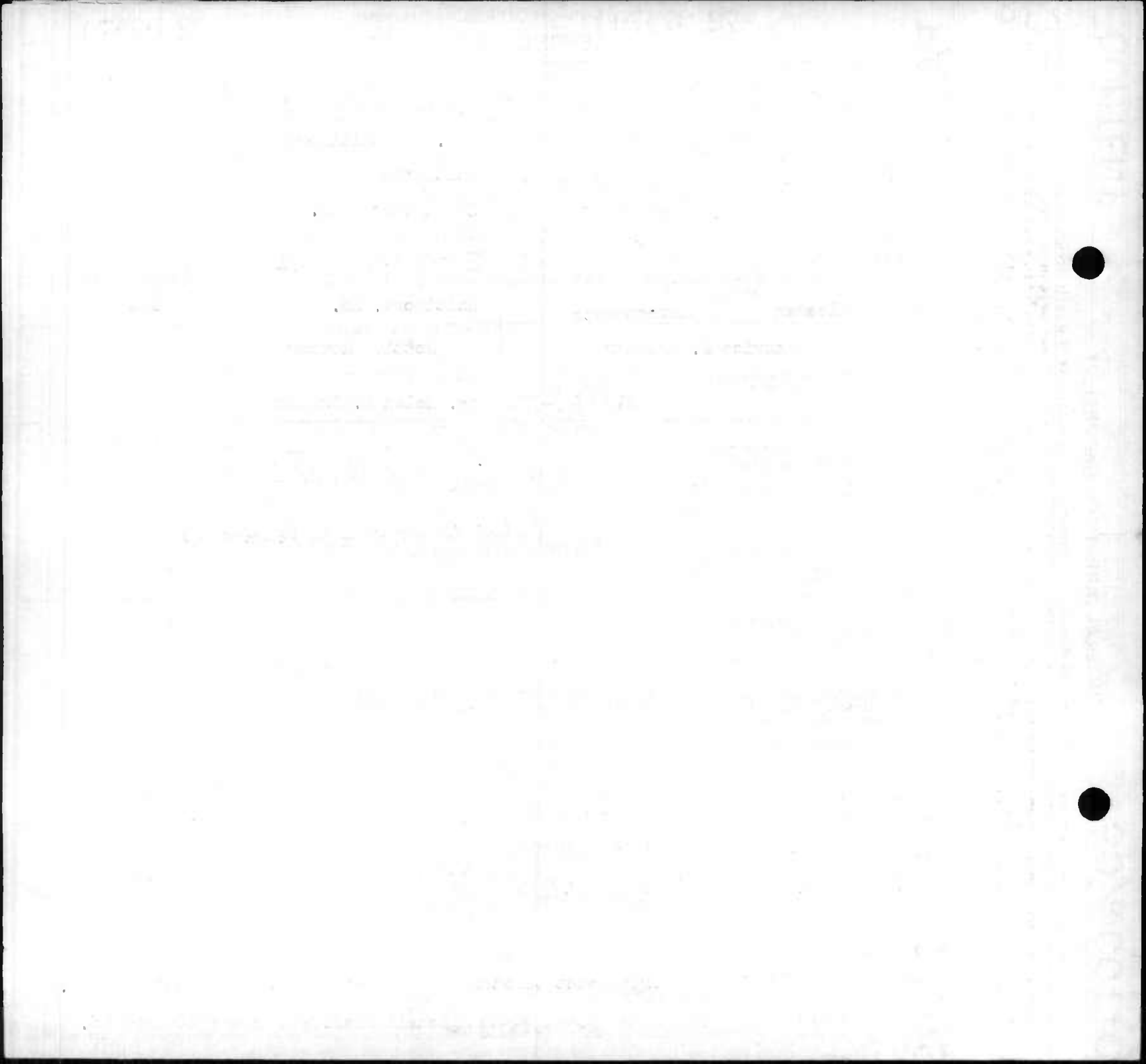
25B. NAME OF REGISTRAR

Sidney W. Wiedefeld

25C. FUNERAL DIRECTOR

Mitchell Wiedefeld Home 6500 York Rd.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07571		BALTIMORE CITY HEALTH DEPARTMENT		72 07571	
BIRTH NO.		CERTIFICATE OF DEATH		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) MARY ELLEN KAPP		2. DATE AND HOUR OF DEATH 8/5/72 1:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY PALTO			
FULL NAME OF HOSPITAL OR INSTITUTION 90 House in the Pines-Belair 8-15-72		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 13 Leslie Avenue-21236					
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1881	9. AGE (In years last birthday) 91	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Altoona, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Carl Bryan		14. MOTHER'S MAIDEN NAME Harriet Grimes	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs. Marion E. Gauer-13 Leslie Ave.-21236	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 4/12/31 7-2-50-9 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Congestive Heart Failure - atrial fibrillation; Chronic Drooping Diaphragm; Diabetes mellitus; Renal Urinary Tract Infection;		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Artificially Induced Heart Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yes	
(B) Chronic Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: yes		(C) _____			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 2/21/72 to 8/5/72 and that (I) (we) last saw the deceased alive on 7/23/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Albert B. Bradley		23B. DATE SIGNED 8/5/72		23C. PHYSICIAN'S NAME (Type) Albert B. Bradley	
23D. ADDRESS Baltimore, Maryland		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-8-72	
24C. NAME OF CEMETERY OR CREMATORY Baltimore, Maryland		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972	
25B. NAME OF REGISTRAR John C. Miller		25C. FUNERAL DIRECTOR John C. Miller Inc		25D. ADDRESS 6415 Belair Rd.-21206	

8-15-1972 - Correction Form from Funeral Director - John C. Miller, Inc., 6415 Belair Rd.
Balto., Md. HRS

B-550

72 07573 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07573

BIRTH NO.

STATE OF MARYLAND-DHMH

REG. NO.

1. NAME OF DECEASED (Type or Print) William Bowman		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 7 Day 24 Year 72 Hour 9:55 a.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2 E. Biddle St.		3. DATE PRONOUNCED DEAD Month 7 Day 24 Year 72 Hour 9:55 a.	
6. SEX male		7. RACE WHITE	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH May 4, 1902		10. AGE (in years last birthday) 70	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1102	
15. MOTHER'S MAIDEN NAME Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 438-12-5686		18. INFORMANT ADDRESS Rev. Frederick Hanna Reisterstown, Md.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ASCVD OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION Aug. 4, 72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/24/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 4, 72	
24C. NAME OF CEMETERY or CREMATORY All Saints Cemetery		24D. LOCATION (City, town, or county) (State) Reisterstown, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972		25B. NAME OF REGISTRAR Frederick Hanna	
25C. FUNERAL DIRECTOR Elmer Funeral Home		ADDRESS Reisterstown, Md. 21136	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

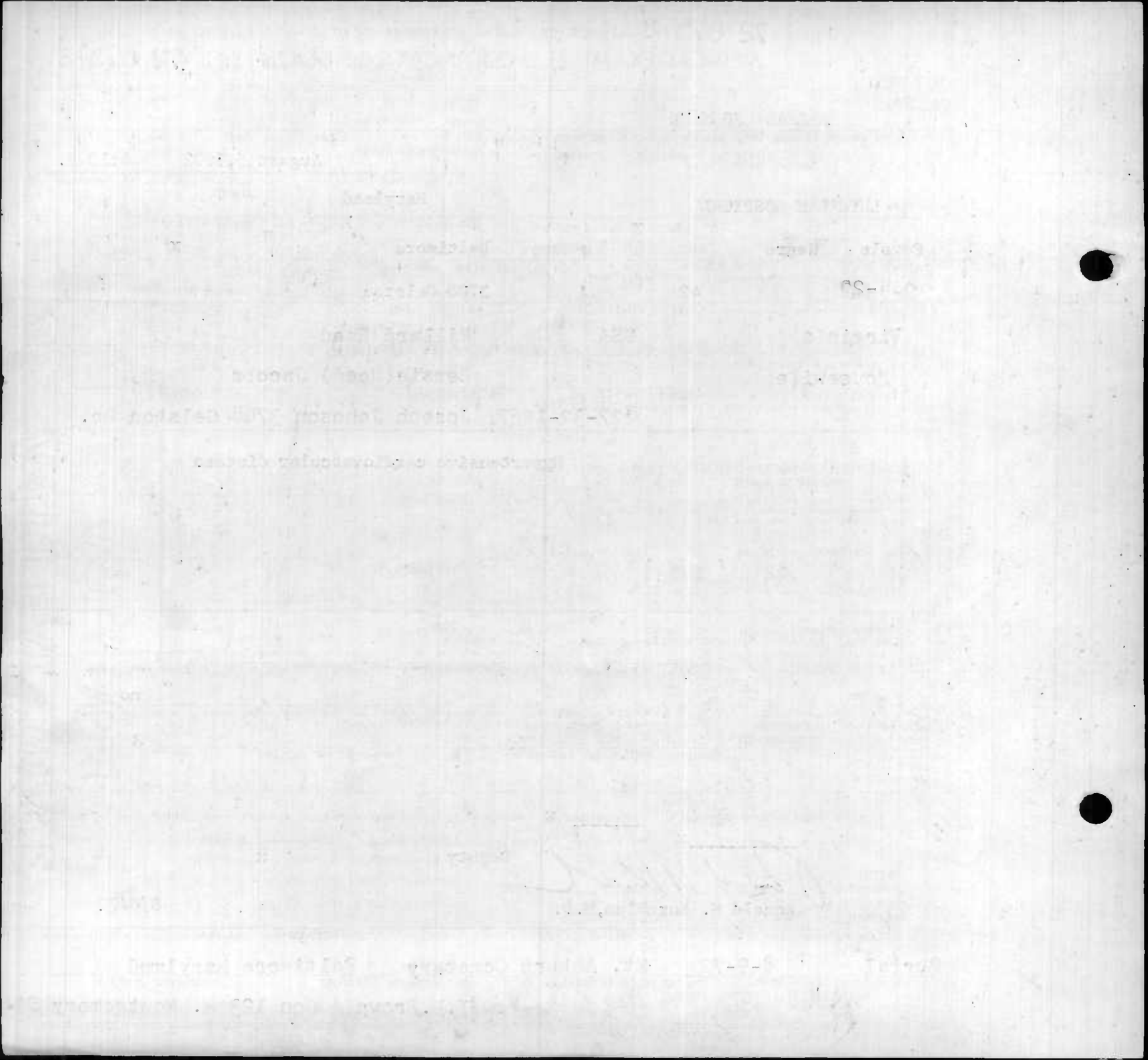
REG. NO.

72 07572

BIRTH NO.

STATE OF MARYLAND-DHMH

1. NAME OF DECEASED (Type or Print) ARLEAN JOHNSON				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 LUTHERAN HOSPITAL				3. DATE PRONOUNCED DEAD Month Day Year Hour August 5, 1972 4:30 P. M.			
6. SEX Female				7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 9-4-29				10. AGE (In years last birthday) 42		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Hillard Reed		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Bessie(Reed) Jacobs				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 227-32-1267	
18. INFORMANT Joseph Johnson				19. CAUSE OF DEATH Hypertensive cardiovascular disease		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				22. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				24. DATE OF OPERATION 8-9-72			
25. CONDITION FOR WHICH OPERATION WAS PERFORMED				26. AUTOPSY? (Yes or No) no			
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) INJURY OCCUR?			
29. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
31. HOW DID INJURY OCCUR?				32. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
33. ACTUAL SIGNATURE Ronald N. Kornblum, M.D.				34. DEPUTY CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
35. DATE SIGNED 8/6/72				36. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
37. 24B. DATE 8-9-72				38. 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery			
39. 24D. LOCATION (City, town, or county) (State) Baltimore Maryland				40. 25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972			
41. 25B. NAME OF REGISTRAR Sidney L. Brown				42. 25C. FUNERAL DIRECTOR I.L. Brown & Son			
43. ADDRESS 123 W. Montgomery St.				44. VS 151-REV. 1/1/68			

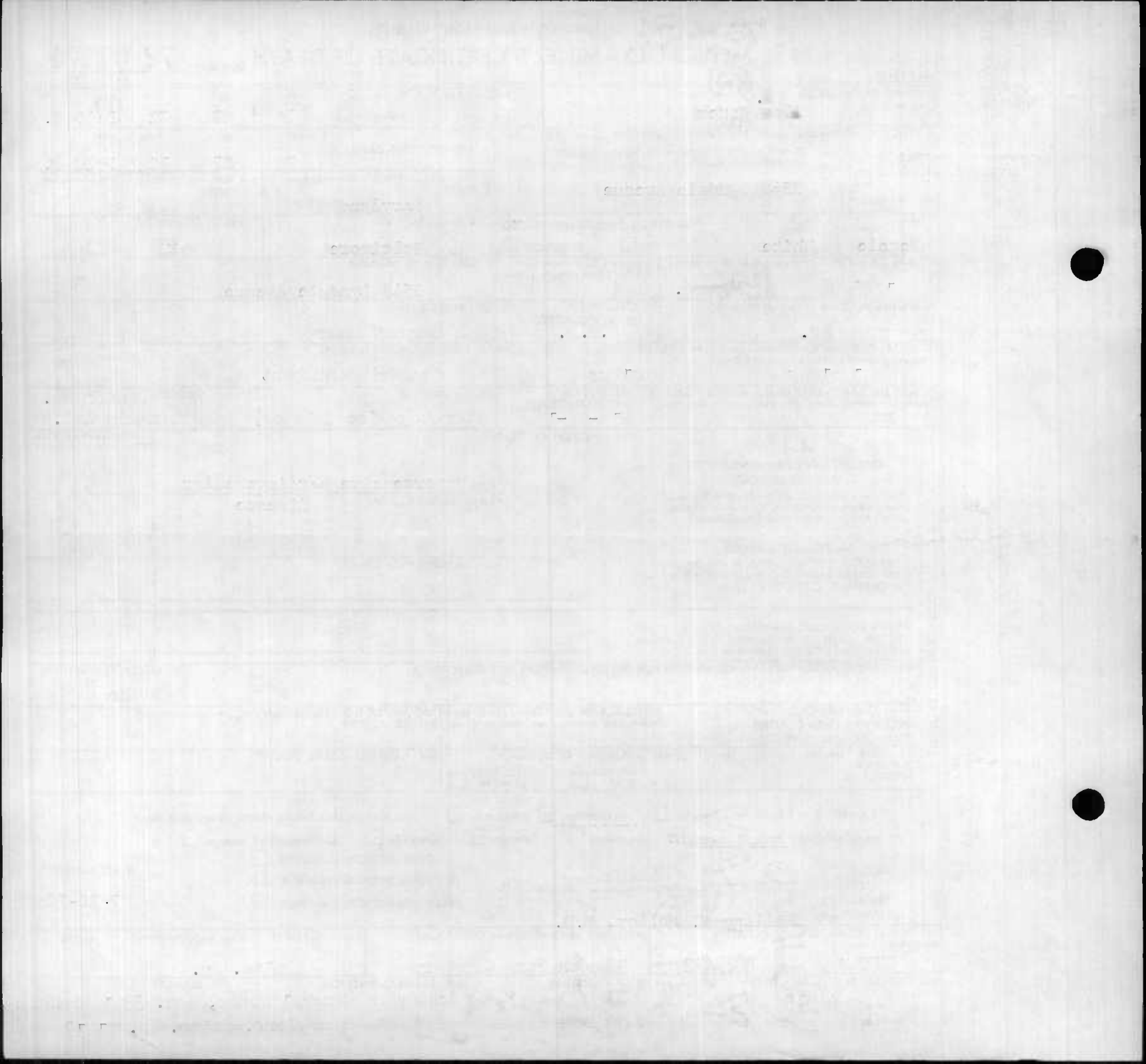


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07574

BIRTH NO.

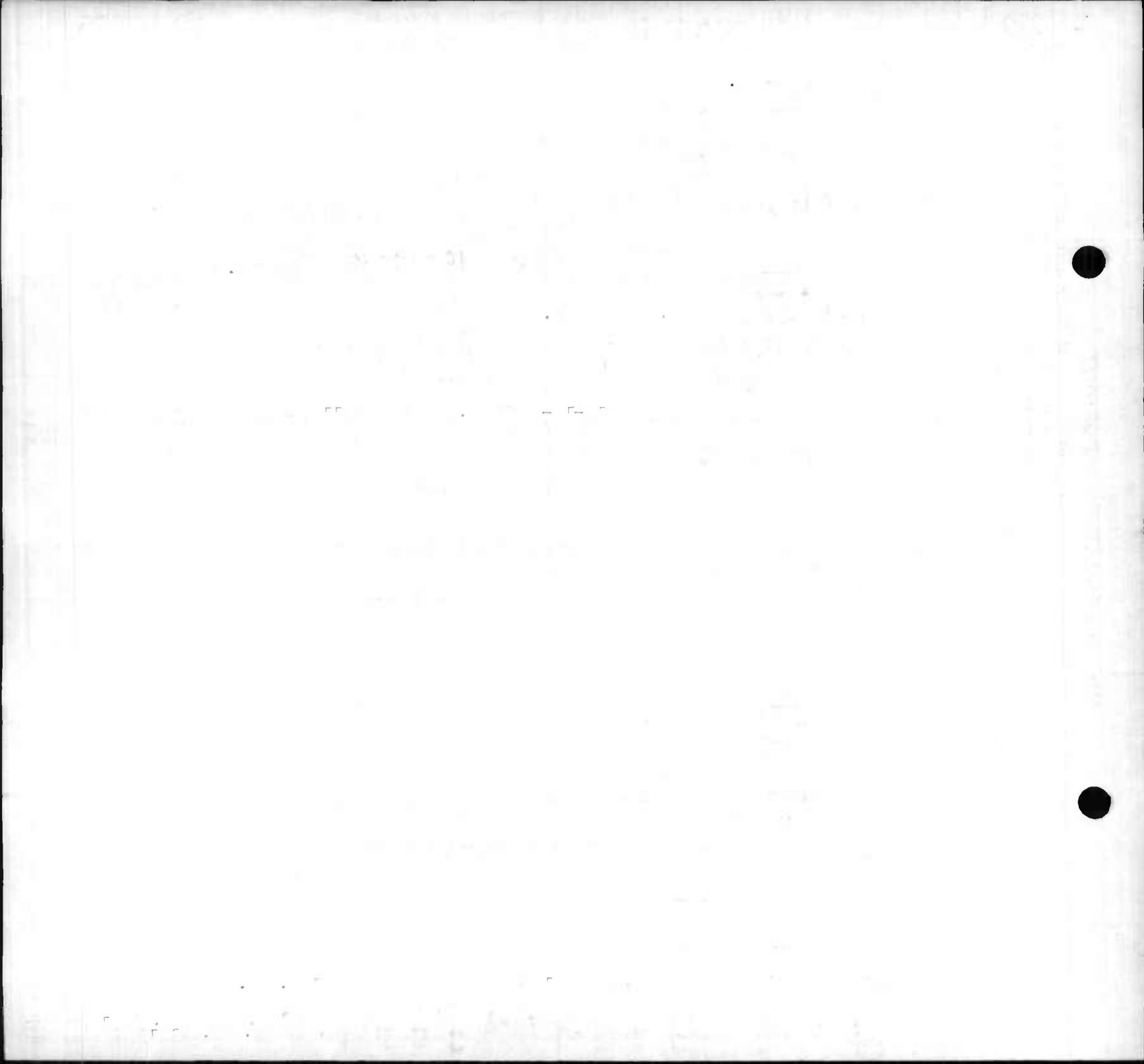
1. NAME OF DECEASED (Type or Print) E. Alma/Sauer		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 7 27 72 Hour 3:10 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3548 Lyndale Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 27 72 3:10 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1/23/98		10. AGE (In years last birthday) 74 yrs.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		14B. KIND OF BUSINESS OR INDUSTRY Hutzlers	
15. MOTHER'S MAIDEN NAME Katherine Daubert		18. INFORMANT Dorothy Wise (sister)	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 215-05-7548	
19. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W P Mulloy EXAMINER'S NAME (Type) William P. Mulloy, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/29/72	
24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972		25B. NAME OF REGISTRAR Andrew W. Horton	
25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.		ADDRESS 3331 Brehms Lane, Balto. Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

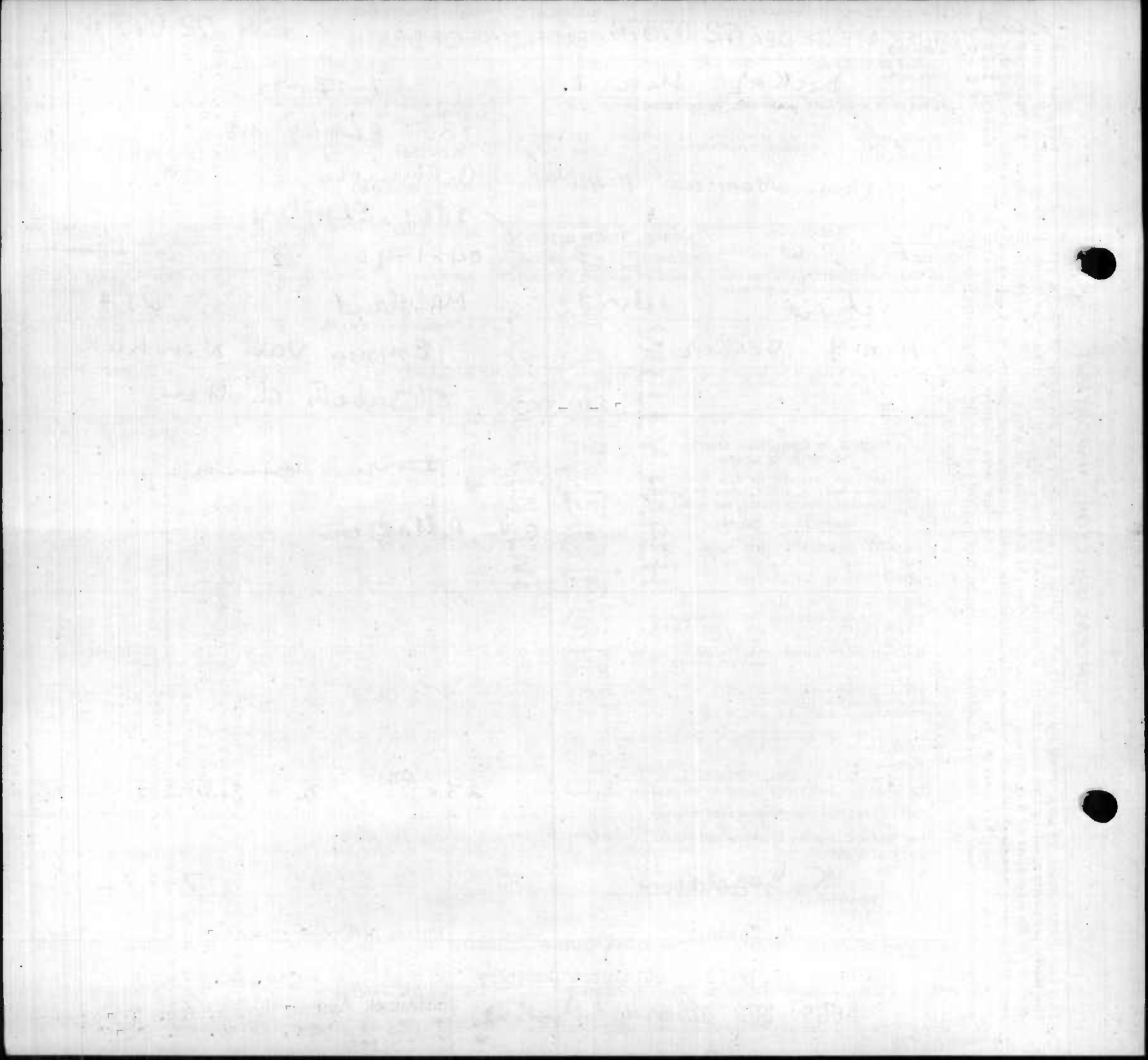
A-400 1		72 07575		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07575	
BIRTH NO.				STATE OF MARYLAND - DEMO			
1. NAME OF DECEASED (Type or Print) ANNE R. AULL				2. DATE AND HOUR OF DEATH 7/27/72 7 PM. 25 7 PM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY A. U. S. A. 2633			
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN H. Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Union Memorial Hospital				E. STREET AND NUMBER 3409 BRENDAN AVE Baltimore Md			
5. SEX Female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-14-26	9. AGE (In years last birthday) 46 yrs.	10. Under 1 Yr. Months: Days: Hours: Mins.	11. Under 24 Hrs. Mins.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10B. KIND OF BUSINESS OR INDUSTRY A. Hoen & Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD KENNEDY				14. MOTHER'S MAIDEN NAME ANNA PCARNEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-16-7867		17. INFORMANT E. Kennedy Aull (son)		ADDRESS same as above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Carcinoma of the Breast (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: with Metastasis to the lungs (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (N) (this hospital) attended the deceased from 06-14-72 19 72 to 7-27 19 72, that (N) (we) last saw the deceased alive on 7/27 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (N) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. Shocair				23B. DATE SIGNED 7/27/72			
23C. PHYSICIAN'S NAME (Type) MAWYA SHOCAIR				23D. ADDRESS M.D. Union Memorial Hospital Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/31/72		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972		25B. NAME OF REGISTRAR Audrey Ingham		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.		ADDRESS 3331 Brehms Lane, Balto. Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

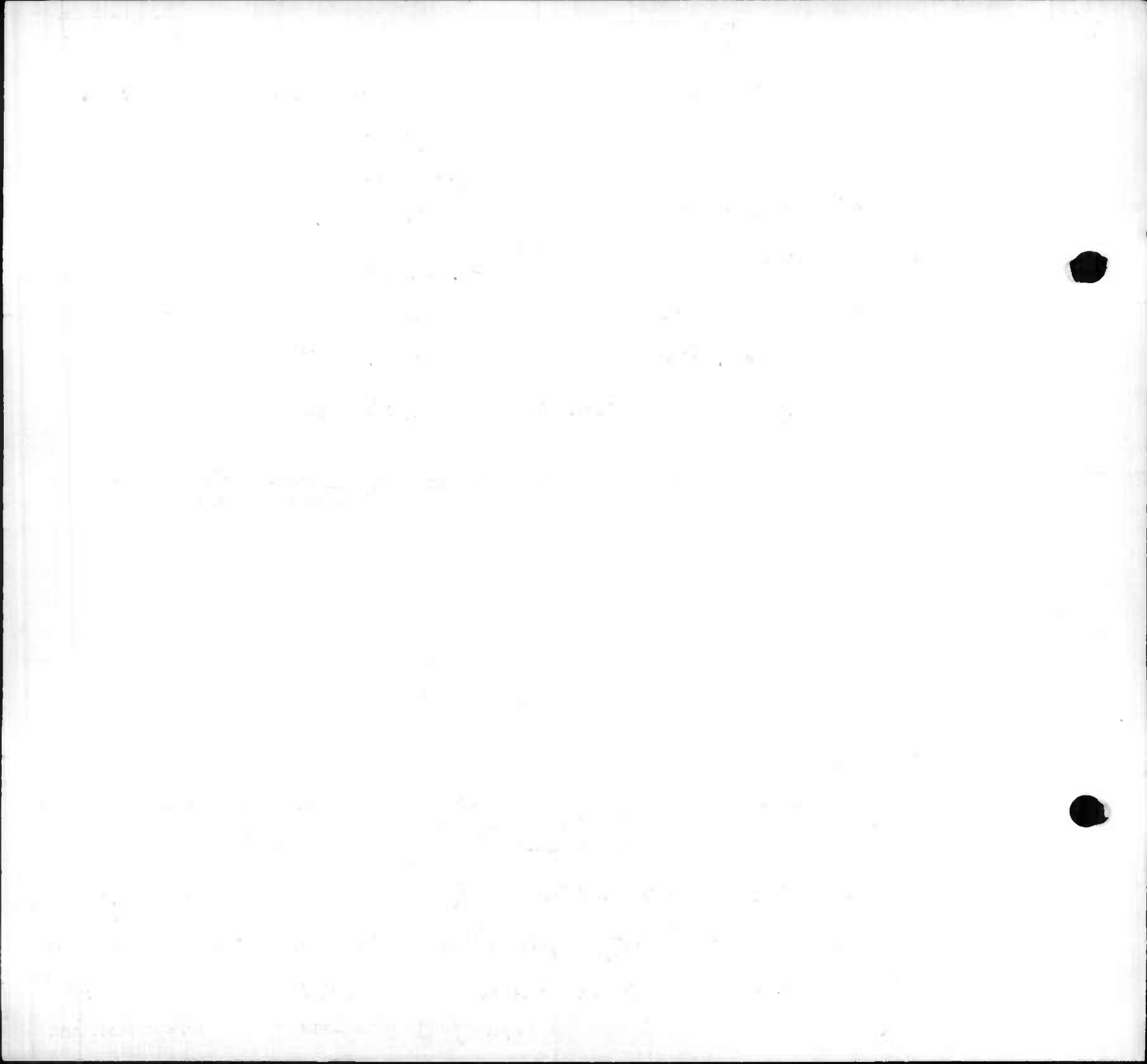
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07576		STATE OF MARYLAND-DMHM	
BIRTH NO. 72 07576				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Decker Alice E.				2. DATE AND HOUR OF DEATH 7-27-72 1230 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE 3807 Elmley Ave.		B. COUNTY 2643	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3807 Elmley			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04-1-90	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10B. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Decker				14. MOTHER'S MAIDEN NAME Emma van New Kirk			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-09-3803		17. INFORMANT. Elizabeth Chilton		ADDRESS	
18. 429.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Severe anemia				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: c.v. Collapse			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 230 AM 1972 to July 27 1972 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE K. Yazdani				Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-27-72	
23C. PHYSICIAN'S NAME (Type) K. Yazdani				23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/29/72		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972		25B. NAME OF REGISTRAR Sidney [Signature]		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.		ADDRESS 3337 Brehms Lane, Balto. Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F. 2601		72 07577 BALTIMORE CITY HEALTH DEPARTMENT		72 07577	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO. STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <i>Emily Fisher</i>		2. DATE AND HOUR OF DEATH <i>August 4, 1972</i> <i>4:30A.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 Ardleigh Nursing Home</i>		4. USUAL RESIDENCE (Where deceased lived. If institution's residence before admission) A. STATE <i>Pennsylvania</i> B. COUNTY <i>V 35</i> C. CITY OR TOWN <i>Philadelphia</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>424 South 48th. Street</i>			
5. SEX <i>female</i>	6. RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 15, 1883</i>	9. AGE (in years last birthday) <i>88</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own-home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>George A. Fisher</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Burlinger</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> <i>none</i>		16. SOCIAL SECURITY NO. <i>200-10-0939</i>		17. INFORMANT <i>Family records</i>	
18. <i>112.4</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>ARTERIO-SCLEROTIC</i> DUE TO, OR AS A CONSEQUENCE OF <i>CARDIO-VAS. DIS.</i> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: _____ (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 YRS.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>0</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>JUNE 13</i> 19 <i>72</i> to <i>AUG. 4</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>AUG. 2</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <i>Lloyd E. Saylor MD</i>		23B. DATE SIGNED <i>AUG-7-1972</i>		23C. PHYSICIAN'S NAME (Type) <i>LLOYD E. SAYLOR, MD</i>	
24A. BURIAL REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-7-72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Darlington Cemetery</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 9 1972</i>		25B. NAME OF REGISTRAR <i>Aditya B. Bhatnagar</i>		25C. FUNERAL DIRECTOR <i>John B. Bhatnagar</i>	
		25D. ADDRESS <i>Towson Maryland</i>			



72 07578 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07578

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MILTON, John C.

2. DATE AND HOUR OF DEATH

8/5/72 5:10 PM

STATE OF MARYLAND-DEMH

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)31 Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

8. COUNTY

Maryland Baltimore

C. CITY OR TOWN

MIDDLE RIVER

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

2132 Southern Rd.

21220

5. SEX

Male

6. RACE

Caucasian

7. MARRIED

NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

8-11-85

9. AGE (In years
last birthday)

86

11. Under 1 Yr.
Months Days

11

12. Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

P.R. ENGINEER

10B. KIND OF BUSINESS OR INDUSTRY

RETIRED

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CALVIN MILTON

14. MOTHER'S MAIDEN NAME

MARY KATHRYN

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown)

No

16. SOCIAL
SECURITY NO.

-

17. INFORMANT

BCH RECORDS 4940 Eastern Avenue 21224

ADDRESS

519.31

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Acute Cor pulmonale 3 day

(B)

DUE TO, OR AS A CONSEQUENCE OF:

COPD & ASCVA

1 yr, 3 mons.

(C)

UTI

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____
that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Hiroshi Mitsumoto

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8/5/72

23C. PHYSICIAN'S
NAME (Type)

HIROSHI MITSUMOTO

DEGREE

23D. ADDRESS

4940 Eastern Ave. Balto. Md. 21224

Baltimore City Hospitals

24A. BURIAL CREMATION,
REMOVAL (Specify)

REMOVAL

24B. DATE

8/6/72

24C. NAME OF CEMETERY OR CREMATORY

GRACE LAND

24D. LOCATION

GREENVILLE

(City, town, or county) (State)

S.C.

25A. DATE REC'D BY HEALTH DEPT.

AUG 9 1972

25B. NAME OF REGISTRAR

Sidney W. Norton

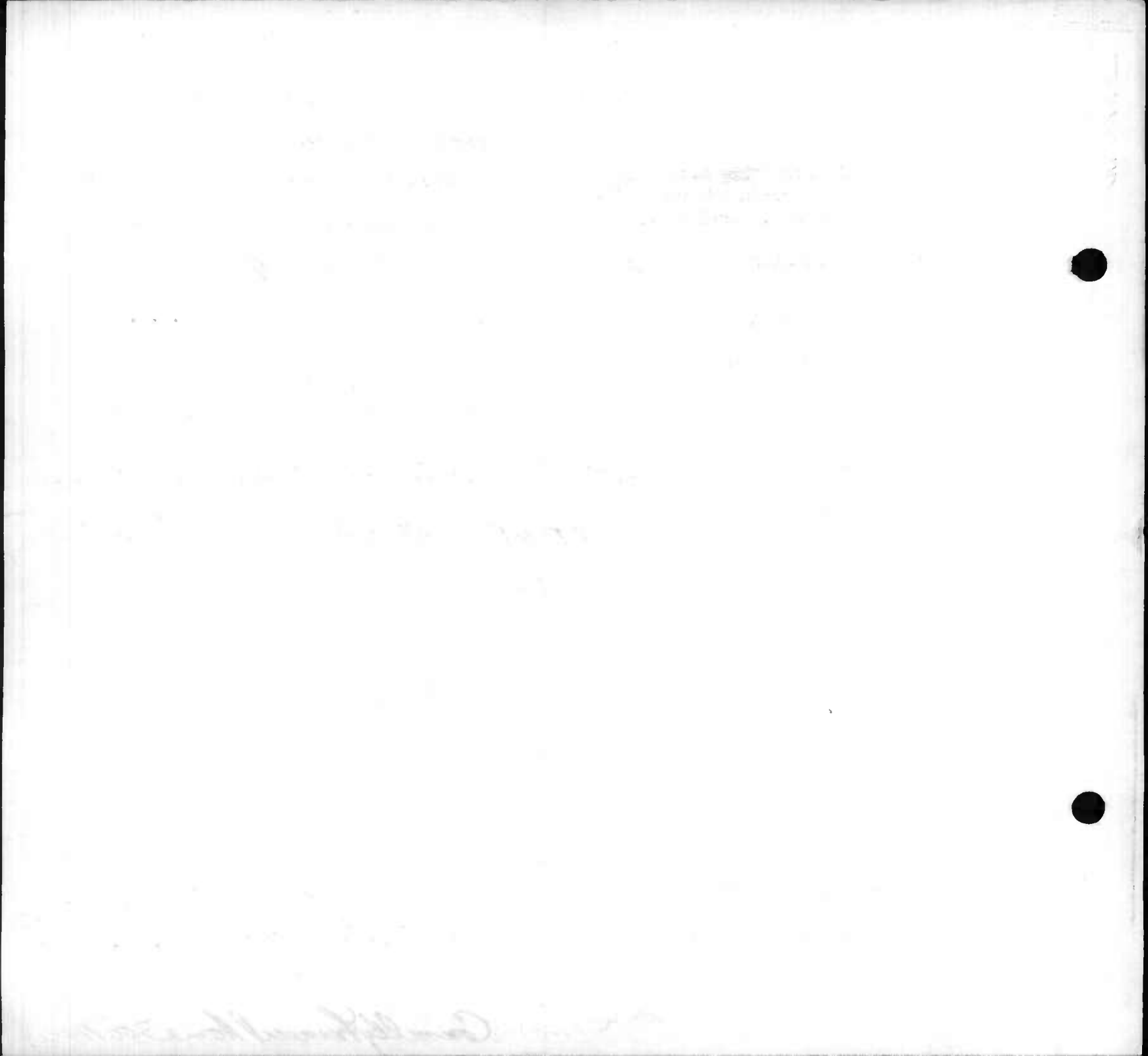
25C. FUNERAL DIRECTOR

C. E. Kelly Funeral Home 3007 Maple

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

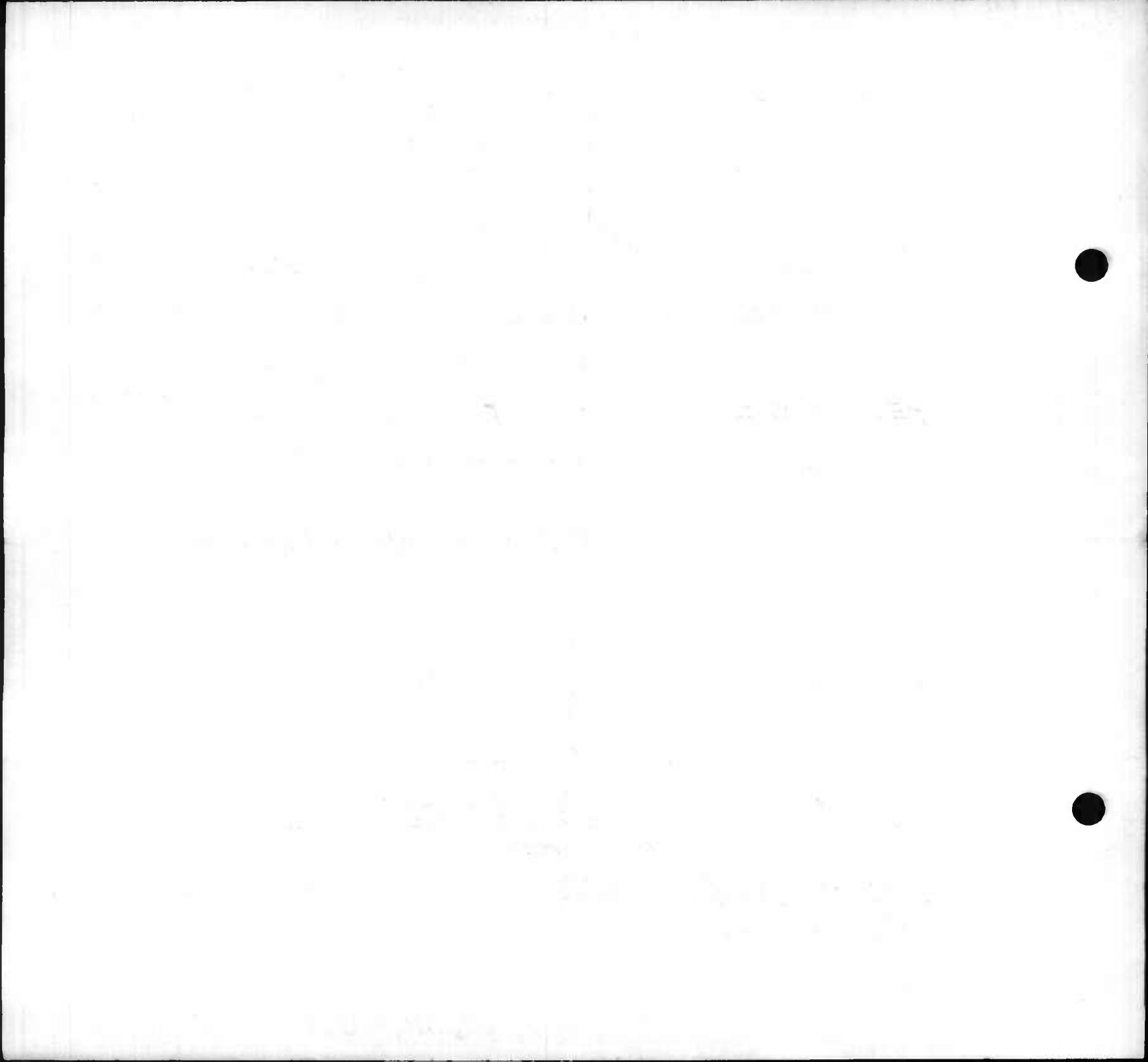
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

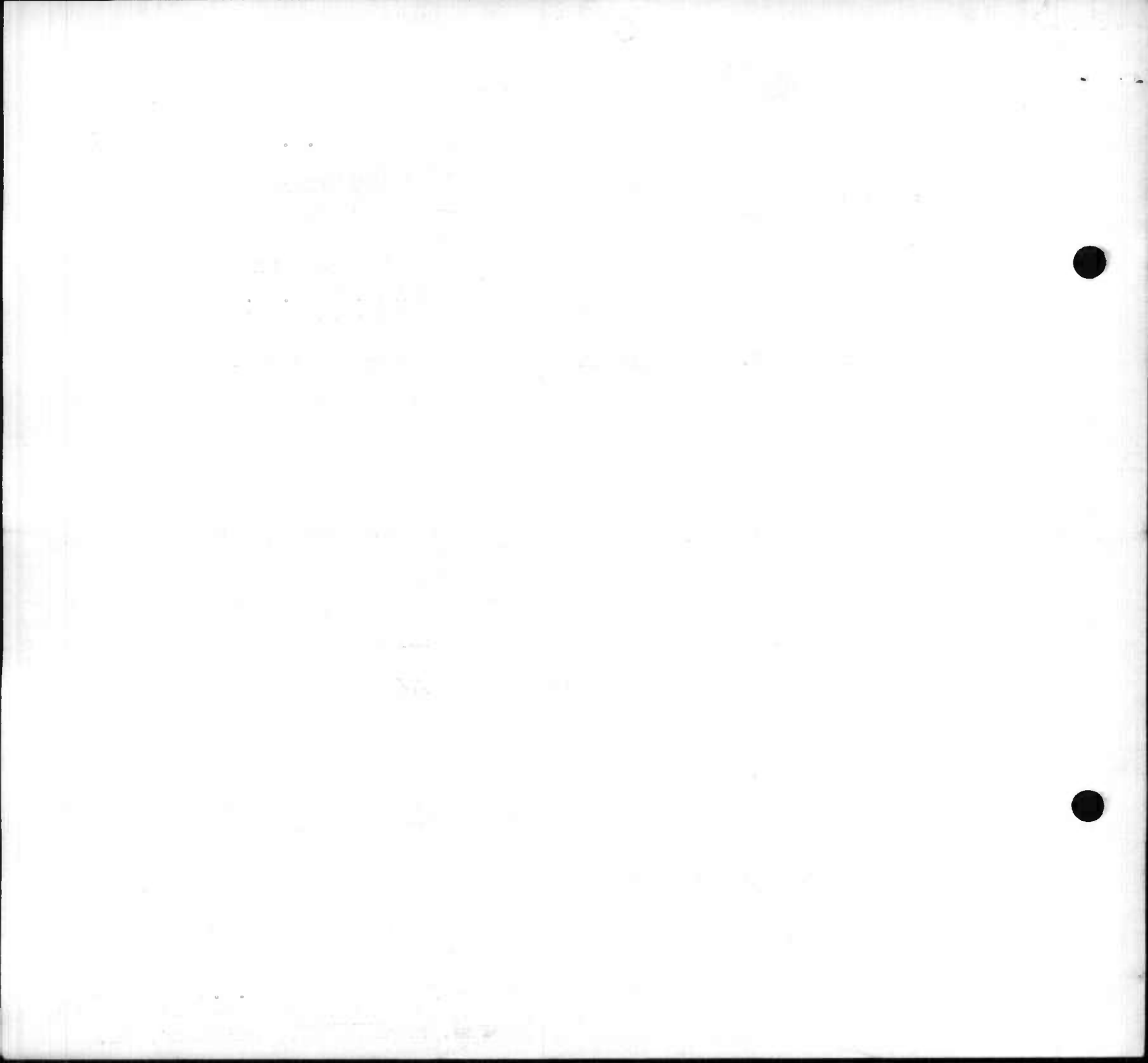
R-2361		72 07579 BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07579
BIRTH NO.		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>EVELYNE RICHTER</u>		2. DATE AND HOUR OF DEATH <u>6 AUG 1972 1515HRS</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u> <u>38</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER <u>1210 Fourth Road</u>				
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/25/16</u>	9. AGE (In years last birthday) <u>55</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PART TIME SEC. WARDEN/MOBILE HOMES</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Amasa Heeter</u>		14. MOTHER'S MAIDEN NAME <u>17th Cooper</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES W.W.II</u>		16. SOCIAL SECURITY NO. <u>308-03-6620</u>		17. INFORMANT <u>FERDINAND RICHTER</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>430.91</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Cerebral Edema</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Ruptured Aneurysm, Cerebral and Cerebral</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>12 DAYS</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>1 AUG 72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Rupt</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (this hospital) attended the deceased from <u>28 JULY 1972</u> to <u>6 August 1972</u> that (we) last saw the deceased alive on <u>6 August 1972</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.				
23A. SIGNATURE <u>Walker L. Robinson, MD</u>		23B. DATE SIGNED <u>6 August 72</u>		23C. PHYSICIAN'S NAME (Type) <u>WALKER L. ROBINSON, MD</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/9/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>HOLLY HILL</u>
24D. LOCATION <u>BALTO, MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 9 1972</u>		
25B. NAME OF REGISTRAR <u>Adrian J. ...</u>		25C. FUNERAL DIRECTOR <u>... Funeral Home, 300 main ave, 21</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

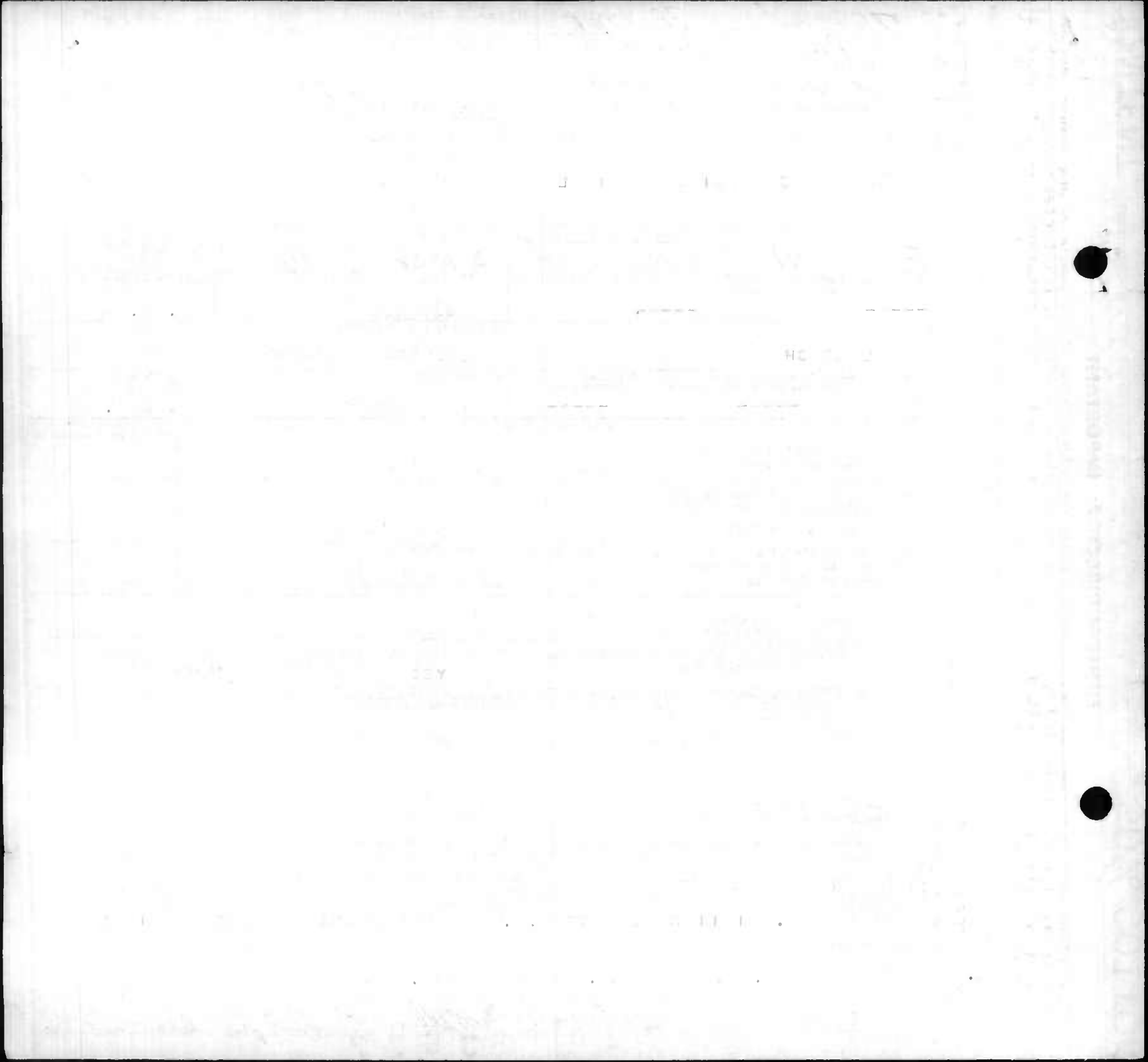
BALTIMORE CITY HEALTH DEPARTMENT 72 07580 CERTIFICATE OF DEATH				X REG. NO. 72 07580 STATE OF MARYLAND-DHMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Jonathan G. Howard Howard Jonathan G. Howard		2. DATE AND HOUR OF DEATH AUG-1-1972 2 AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY P.G. 6600 C. CITY OR TOWN Upper Marlboro, Md. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 9525 SHERWOOD DR. UPP. MARLBORO		
5. SEX M	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-17-47	9. AGE (In years last birthday) 24 XXXX	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C. XXXXXXXXXXXXXXXXXX	
13. FATHER'S NAME Edward D. Howard			14. MOTHER'S MAIDEN NAME Mary E. DeVail		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Mrs. Edw. Howard 9525 SHERWOOD DRIVE UPP. MARLBORO	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 512X1 This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST - 2m5 (B) CARDIAC ARRYTHMIA - 5 DAY DUE TO, OR AS A CONSEQUENCE OF: (C) TENSION - PNEUMOTHORAX APPROXIMATE INTERVAL (Hrs.) BETWEEN ONSET AND DEATH 600		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			MENTAL - INCAPACITY		
19A. DATE OF OPERATION 1/7/27/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CHEST TUBE INSERTION - NO		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-27 1972 to 1-8 1972 that (I) (we) last saw the deceased alive on 7-31 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. J. M. Reddy MD			23B. DATE SIGNED 8/1/72		23C. PHYSICIAN'S NAME (Type) G. J. M. REDDY
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 8-4-72		24C. NAME OF CEMETERY or CREMATORY Resurrection Cemetery
24D. LOCATION Clinton, P.G., Maryland			25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972		
25B. NAME OF REGISTRAR Sidney J. Howard			25C. FUNERAL DIRECTOR Robt E Wilhelm 4308 Suitland Rd., Suitland, Md.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. 72 07581			
BIRTH NO. 7 PAULA BEACH										STATE OF MARYLAND-DMH			
1. NAME OF DECEASED (Type or Print) JOHNS HOPKINS HOSP					2. DATE AND HOUR OF DEATH 8-3-72 1540P								
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE DELAWARE B. COUNTY V07								
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL					C. CITY OR TOWN DELMAR			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
E. STREET AND NUMBER RD # 3													
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-10-56	9. AGE (In years last birthday) 16	11. Under 1 Yr. Months: 5 Days: 23		12. Under 24 Hrs. Hours: 16 Mins.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME PAUL BEACH					14. MOTHER'S MAIDEN NAME LEONORA Beach								
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) no					16. SOCIAL SECURITY NO. -----		17. INFORMANT Paul Beach					ADDRESS Rd #3 Delmar, Del.	
18. 289.91 CAUSE OF DEATH													
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH													
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)													
ANTECEDENT CAUSES													
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.													
(A) IMMEDIATE CAUSE Pseudomonas Sepsis													
DUE TO, OR AS A CONSEQUENCE OF:													
(B) Bone Marrow Depression													
DUE TO, OR AS A CONSEQUENCE OF:													
(C) UNKNOWN													
II													
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).													
Post-neurotic aneurysm													
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 7-18 19 72 to 8-3 19 72 that (I) (we) last saw the deceased alive on 8-3 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE D. William Schlott, M.D.								Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/5/72			
23C. PHYSICIAN'S NAME (Type) D. WILLIAM SCHLOTT M.D.								23D. ADDRESS THE JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE Aug. 7, 1972		24C. NAME OF CEMETERY OR CREMATORY St. Stephens Cem.		24D. LOCATION (City, town, or county) (State) Delmar Sussex Delaware					
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972				25B. NAME OF REGISTRAR Audrey Ingham				25C. FUNERAL DIRECTOR ADDRESS William M. Schlott, Delmar Del.					



72 07582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 07582
STATE OF MARYLAND-DEPT

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE BURKE

2. DATE AND HOUR OF DEATH

3:00 pm 8/6/72 5:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 BALTIMORE CITY HOSPITAL
4940 EASTERN AVE
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md. B. COUNTY 2609

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

934 Conkling St 21224

5. SEX

Male ☒

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12/15/12

9. AGE (In years last birthday)

59

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

STEVEDORE

11. BIRTHPLACE (State or foreign country)

BALTO., MD.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Robert L. Burke

14. MOTHER'S MAIDEN NAME

Della Pugh

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

212-10-1319

17. INFORMANT

BCH: RECORDS 4940 Eastern Avenue Baltimore, Maryland 21224

ADDRESS

934 Conkling

18. 162.1 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Cardiac Standstill

(B) DUE TO, OR AS A CONSEQUENCE OF:

CA of lung

(C) DUE TO, OR AS A CONSEQUENCE OF:

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

Aug 1

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

-

20A. AUTOPSY? (Yes or No)

no.

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

-

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 22 1972 to August 6 1972, that (I) (we) last saw the deceased alive on Aug 6 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Philip Smith MD

Attending Phys. ☒Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

8/6/72

23C. PHYSICIAN'S NAME (Type)

PHILIP L. SMITH MD

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland BALTO. CIV Hospital 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8/10/72

24C. NAME of CEMETERY or CREMATORY

PARKWOOD

24D. LOCATION (City, town, or county) (State)

BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.

AUG 9 1972

25B. NAME OF REGISTRAR

Sidney Johnston

25C. FUNERAL DIRECTOR

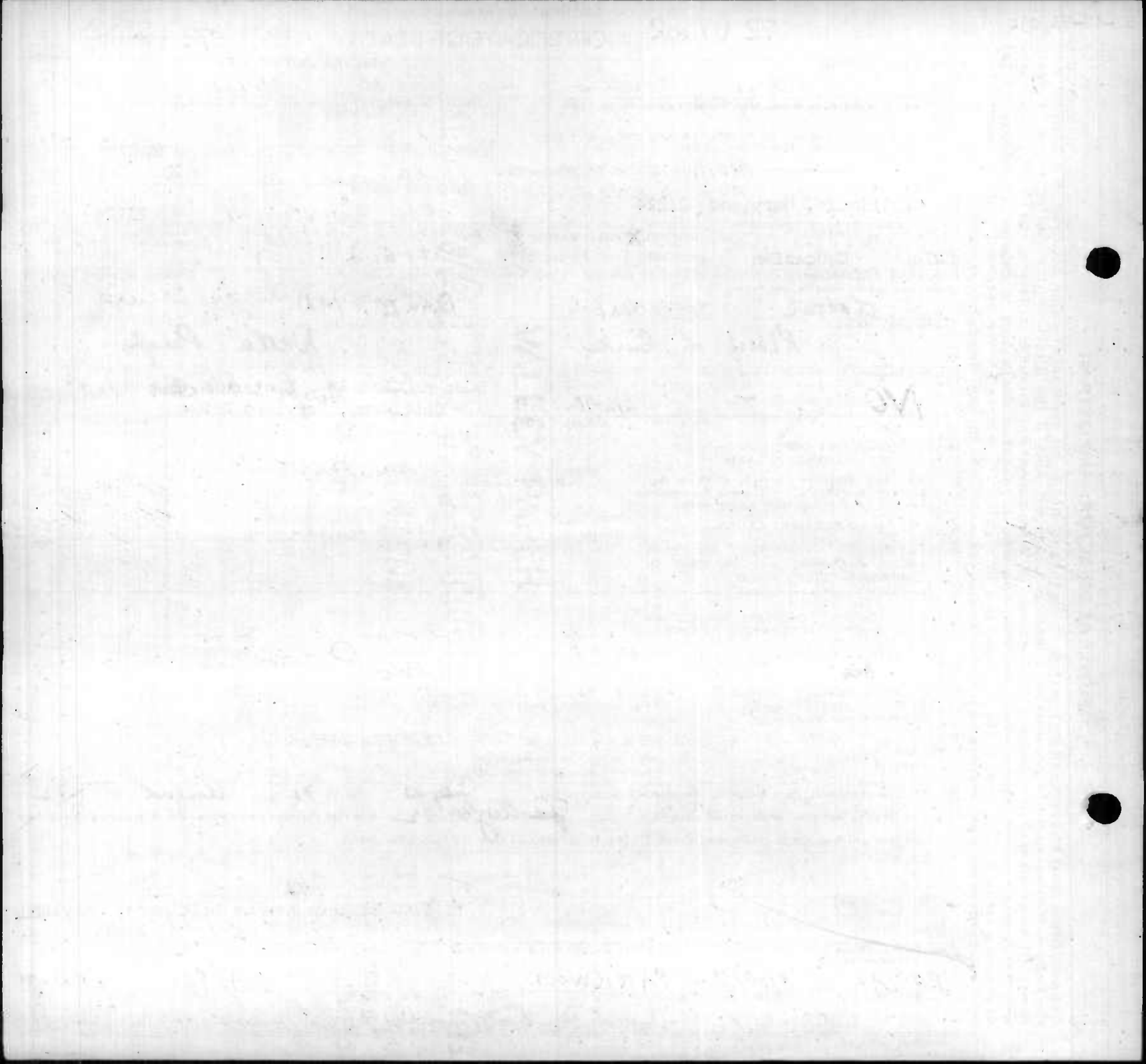
Connelly Funeral Home

ADDRESS

300 Mace Ave, 21

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



72 07583

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07583

BIRTH NO.

STATE OF MARYLAND-DEMH

REG. NO.

1. NAME OF DECEASED (Type or Print) THOMAS M. HART				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3529 Old York Road				3. DATE PRONOUNCED DEAD Month Day Year Hour August 5, 1972 9:55 A. M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 903							
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH APRIL 16-1920		10. AGE (In years last birthday) 52		E. STREET AND NUMBER 3529 Old York Road			
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME THOMAS A HART			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HANDYMAN		14B. KIND OF BUSINESS OR INDUSTRY ATLANTIC DROOM CO.		15. MOTHER'S MAIDEN NAME THERESA HART			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W. W. II		17. SOCIAL SECURITY NO. 214-18-141		18. INFORMANT THERESA HART		ADDRESS SAME AS ABOVE	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 7		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Marvin S. Platt</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Marvin S. Platt, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8/6/72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/9/72		24C. NAME of CEMETERY or CREMATORY LAKE VIEW MEMPK		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972		25B. NAME OF REGISTRAR Andrew W. Horton		25C. FUNERAL DIRECTOR Caprony Funeral Home		ADDRESS 300 mareau Balt 21	

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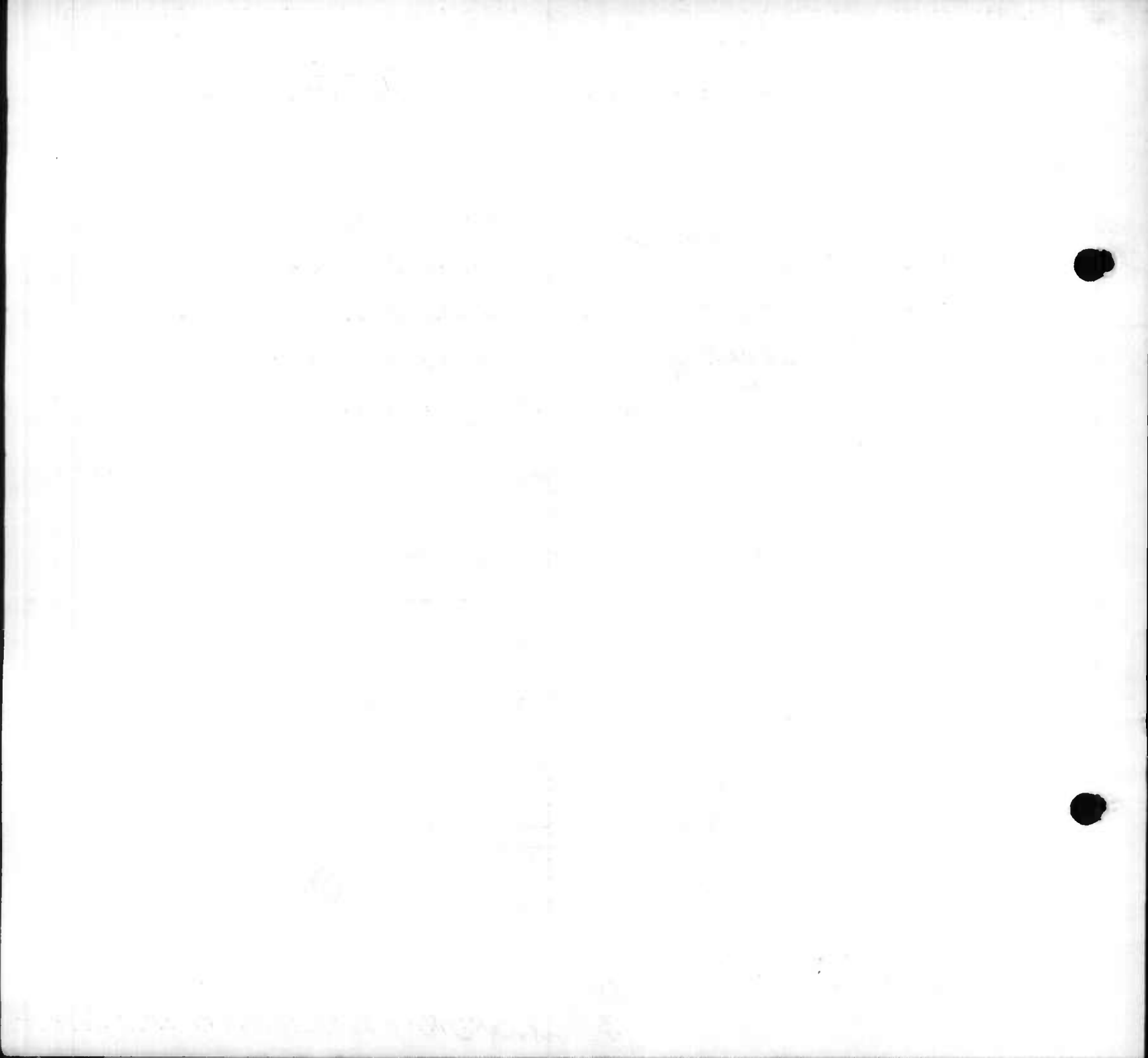
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07584		REG. NO. 72 07584		STATE OF MARYLAND-DHMH	
BIRTH NO.				CERTIFICATE OF DEATH				M.	
1. NAME OF DECEASED (Type or Print) ADAM LEWANDOWSKI				2. DATE AND HOUR OF DEATH AUGUST 3, 1972					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 00				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2417 FOSTER AVENUE		A. STATE MARYLAND		B. COUNTY 103	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 2417 FOSTER AVENUE					
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 24 1908		9. AGE (In years last birthday) 64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LONGSHOREMAN				10B. KIND OF BUSINESS OR INDUSTRY MARITIME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME IGNATIUS LEWANDOWSKI				14. MOTHER'S MAIDEN NAME MARY HARTNICK					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 215-09-3415		17. INFORMANT MRS. LILLIAN LEWANDOWSKI			
						ADDRESS 2417 FOSTER AVE			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 161.0				CAUSE OF DEATH (A) IMMEDIATE CAUSE METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF: CA OF VOCAL CORD (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months years	
19. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Gracita V. Patricia R.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/3/72			
23C. PHYSICIAN'S NAME (Type) GRACITA V. PATRICIA R.D.				23D. ADDRESS 1110 PEEHART WOOD ROAD (BALT. MD)					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/8/72		24C. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE MD.			
25A. DATE REC'D BY HEALTH/DEPT. AUG 9 1972		25B. NAME OF REGISTRAR Sidney [Signature]		25C. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI		ADDRESS 2525 FLEET ST.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07585 BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 72 07585

CERTIFICATE OF DEATH

Dr. F. Frederick Ruzicka Sr.

1. NAME OF DECEASED (Type or Print) **RUZICKA, F. Frederick Sr.**

2. DATE AND HOUR OF DEATH **8-3-1972 5:45 P.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD **8-22-72 THE JOHNS HOPKINS HOSPITAL**

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE **MARYLAND**

B. COUNTY **831**

C. CITY OR TOWN **BALTIMORE**

D. INSIDE CITY LIMITS? YES ☒ NO ☐

E. STREET AND NUMBER **2300 ERDMAN AVE.**

5. SEX **MALE**

6. RACE **WHITE**

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH **6-6-22-91**

9. AGE (In years last birthday) **81**

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Physician**

11. BIRTHPLACE (State or foreign country) **Md.**

12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **FRANK RUZICKA**

14. MOTHER'S MAIDEN NAME **MARY KOPECKI**

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) **no**

16. SOCIAL SECURITY NO. **216-44-1481**

17. INFORMANT **Mrs. Anne K. Ruzicka** ADDRESS **same**

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH **Acute intra-cerebral bleed**

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH **5 hours**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. **ASCVD**

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: **20 years**

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION **8/3/72**

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) **NO**

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED While At ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **8/3/ 5pm 1972** to **8/3 5:45p 1972** that (I) (we) last saw the deceased alive on **August 3, 1972** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE **James K. Brown MD**

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type) **JAMES K. BROWN MD**

23D. ADDRESS **THE JOHNS HOPKINS HOSPITAL**

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial**

24B. DATE **8/7/72**

24C. NAME of CEMETERY or CREMATORY **Most Holy Redeemer**

24D. LOCATION (City, town, or county) (State) **Balto. Md.**

25A. DATE REC'D BY HEALTH DEPT. **AUG 9 1972**

25B. NAME OF REGISTRAR **Sidney Schuster**

25C. FUNERAL DIRECTOR **Leonard J. Ruck Inc. Balto. Md.**

25D. ADDRESS

VS 150-REV. 1/1/68

8-22-1972 - Letter from The Johns Hopkins Hospital, Baltimore, Md. by Austin Holzer, Jr.
Director of Admissions. HRS
Also correction form from Funeral Director, Ruck Funeral Home, Balto., Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07586

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 07586
STATE OF MARYLAND-DEHME

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MORA G. JONES		2. DATE AND HOUR OF DEATH 3 AUGUST 1972 9 00 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1202		
FULL NAME OF HOSPITAL OR INSTITUTION 00			C. CITY OR TOWN Baltimore		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3409 GREENWAY BALTIMORE, MD 21218			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 3409 Greenway					
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1885	9. AGE (In years lost birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John W. Shores		14. MOTHER'S MAIDEN NAME Elizabeth Tignor	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 262-20-3232D		17. INFORMANT ADDRESS Mrs. M. Evelyn Schumacher, Balto. Md.	
18. 437.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTHRAZIC SCIENTIFIC GENERAL VASCULAR DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 2 mos. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 18 MAY 19 72 to 3 AUG 19 72 , that (I) (last) saw the deceased alive on 26 JUNE 19 72 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.					
23A. SIGNATURE J. Dixon Hills				23B. DATE SIGNED 4 Aug 72	
23C. PHYSICIAN'S NAME (Type) J. Dixon Hills				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/72.		24C. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	
24D. LOCATION (City, town, or county) (State) Chance, Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972		25B. NAME OF REGISTRAR Leonard J. Ruck, Inc.		25C. FUNERAL DIRECTOR ADDRESS Balto. Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07587		REG. NO. 72 07587	
CERTIFICATE OF DEATH							
STATE OF MARYLAND - DISTRICT							
BIRTH NO.		5.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Elsie Diffenbaugh		8-4-72		2:05 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital, Inc.				A. STATE Maryland		B. COUNTY 2702	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2808 Montebello Terrace							
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-5-89	9. AGE (In years last birthday) 83	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Schmidt				14. MOTHER'S MAIDEN NAME Annie L. Snyder			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 218-18-5372D		17. INFORMANT Mrs. Oleda Brauer		ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 412.419.250.9 Pneumonia Cerebrovascular Accident Arteriosclerotic Cardiovascular disease Diabetes Mellitus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (Name) attended the deceased from 4-24-72 to 8-4-72, and that (1) (Name) last saw the deceased alive on 8-4-72, and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John E. Seibel, M.D.				23B. DATE SIGNED 8/9/72			
23C. PHYSICIAN'S NAME (Type) John E. Seibel, M.D.				23D. ADDRESS Mercy Hospital, Inc. 301 St. Paul Place			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/72		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972		25B. NAME OF REGISTRAR Leonard J. Ruck, Inc.		25C. FUNERAL DIRECTOR ADDRESS Balto. Md.			

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1947-1948

278-10-1340 Mrs. Clara Turner

(page)

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07588	
72 07588 17-520 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) EVRETT R. MENGE			2. DATE AND HOUR OF DEATH August 6, 1972 11:00 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Balto C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6 N. Broadway		
5. SEX M	6. RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/07	9. AGE (In years lost birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMAN		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) UNKNOWN.	
13. FATHER'S NAME UNK			12. CITIZEN OF WHAT COUNTRY? USA.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 337-01-7098		17. INFORMANT ADDRESS GEORGE PRASCH 1802 E PRATT STREET
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 571.91			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: GI Bleeding		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Cirrhosis of the liver DUE TO, OR AS A CONSEQUENCE OF:		UNKNOWN.
			(C) Hepatic coma.		3 weeks
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II Pulmonary Embolus			2 weeks		
19A. DATE OF OPERATION 0 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 18 1972 to August 6 1972 that (I) (we) last saw the deceased alive on August 6 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce K. Lloyd MD				23B. DATE SIGNED August 6, 1972	
23C. PHYSICIAN'S NAME (Type) BRUCE K. LLOYD.				23D. ADDRESS 601 N. BROADWAY	
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION AUG 9 1972		24B. DATE SECURITY PROCESS INC		24C. LOCATION (City, town, or county) (State) 301 FREDERICK ROAD BALD MD 21228	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972		25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR ADDRESS DIPPER BROS INC 1800 E LOMBARD ST ST	

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and

and

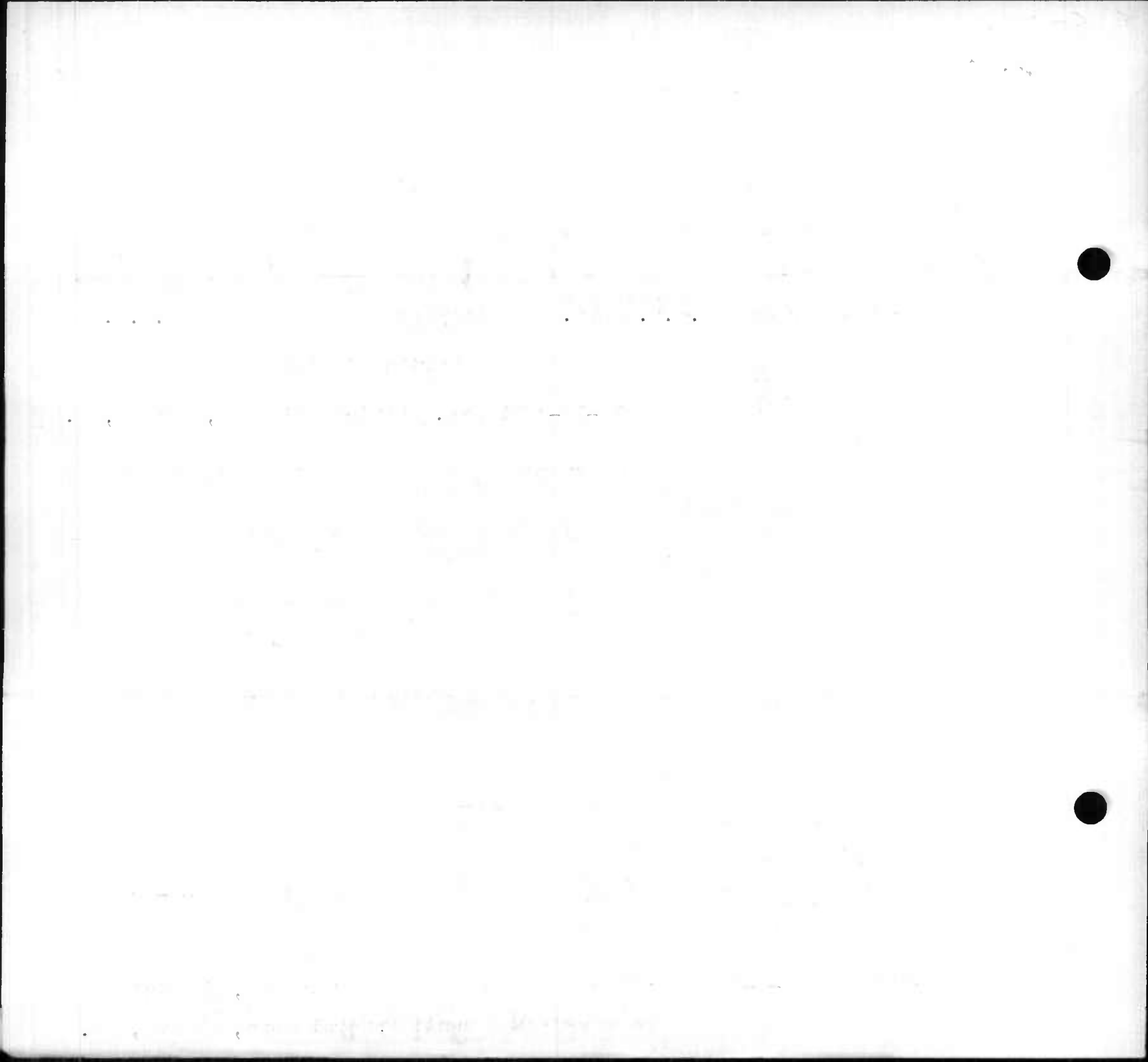
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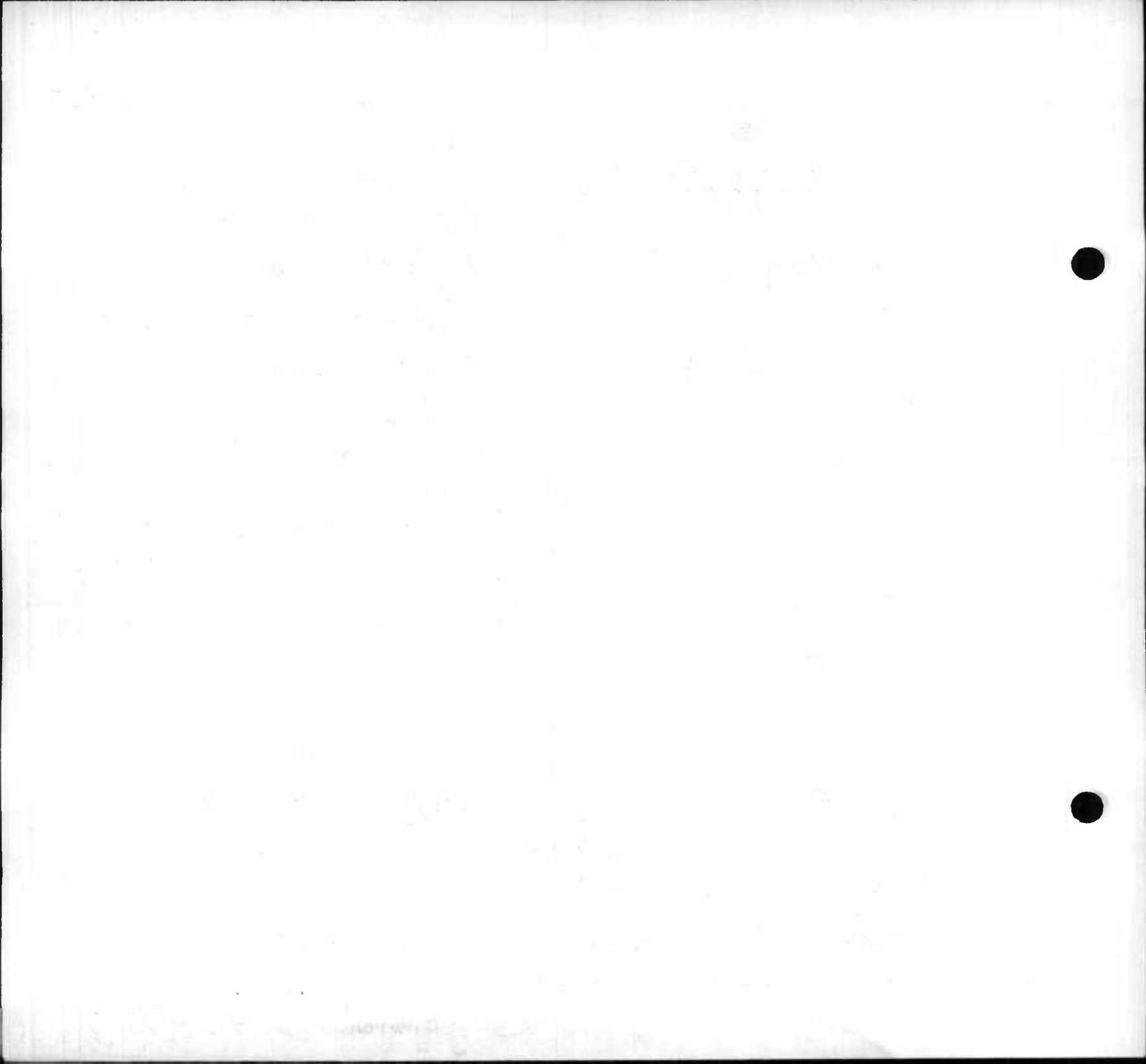
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 07589		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 72 07589	
1. NAME OF DECEASED (Type or Print) PAUL SIMMONS			2. DATE AND HOUR OF DEATH 8-4-72 10:00 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION University of Maryland Hosp.			A. STATE MD B. COUNTY CHARLES		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN POMFRET D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER None 5800		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/3/20	9. AGE (In years last birthday) 51	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Explosive Worker		10B. KIND OF BUSINESS OR INDUSTRY Ordinance A & E N.O.S. Govt.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph Simmons		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 214-14-4551		17. INFORMANT Mrs. Patricia Simmons, Pomfret, Md.	
18. 395.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Rupture Mitral Aortic Aneurysm			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hours		
[This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) Aortic Valve replacement 4/25/72 DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			Aortic Stenosis Repair		
19A. DATE OF OPERATION 8/4/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-22 19 72 to 8/4 19 72 that (I) (we) last saw the deceased alive on 8/4/72 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose V. Iglesias M.D. DEGREE				23B. DATE SIGNED 8-4-72	
23C. PHYSICIAN'S NAME (Type) Jose V. Iglesias M.D. DEGREE				23D. ADDRESS University of Md. Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-8-72		24C. NAME of CEMETERY or CREMATORY Woodbine Cemetery	
				24D. LOCATION (City, town, or county) (State) Manassas, Virginia	
25A. DATE REC'D BY HEALTH DEPT. AUG 9 1972		25B. NAME OF REGISTRAR Andrew J. Boston		25C. FUNERAL DIRECTOR Huntt Funeral Home, Waldorf, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07590	
72 07590 CERTIFICATE OF DEATH					
BIRTH NO. STATE OF MARYLAND - DEATH		1. NAME OF DECEASED (Type or Print) SHARP, CHARLES			
2. DATE AND HOUR OF DEATH		8-3-72 9:55 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 George Washington Nursing Home 607 Pennsylvania Ave.			A. STATE md. B. COUNTY 704		
C. CITY OR TOWN			D. INSIDE CITY LIMITS?		
Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER			717 N. Conline St.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
MALE	BLACK		7/11/02	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
LABORER				Baltimore md	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Charles Sharp			MARY BARNES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Unknown		218-03-5603		Chart	
18. 436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PNEUMONIA CHRONIC PYELONEPHRITIS (B) DUE TO, OR AS A CONSEQUENCE OF: STROKE (C) ACUTE RENAL SHUTDOWN 1969		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 6 YRS. 6 YRS.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 26 MAY 1972 to 3 Aug 1972 that (2) (we) last saw the deceased alive on 3 Aug 1972 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Richard Tyson, M.D.			8-3-72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Richard Tyson, M.D.			936 W. North Ave.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8-7-72		Mt Auburn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 9 1972		Sidney Whitely		Wm. G. March	
				ADDRESS 1928 North...	



T-460

BALTIMORE CITY HEALTH DEPARTMENT

72 07591

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07591

REG. NO.

BIRTH NO. <u>72 07591</u>		REG. NO. <u>72 07591</u>	
1. NAME OF DECEASED (Type or Print) CHARLES TAYLOR		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 6 1972 9:45 p.m.	
6. SEX male		7. RACE negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 11-10-44		10. AGE (in years lost birthday) 27	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James A Thomas		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 904	
15. MOTHER'S MAIDEN NAME Margaret Taylor		16. INFORMANT Jacqueline Taylor 442 E 28th St.	
17. SOCIAL SECURITY NO. 213-44-7548		18. ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E965X1		CAUSE OF DEATH Gunshot wound of aorta, hemoperitoneum	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
22A. DATE OF OPERATION 2		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 738 E. 32nd St.		22D. HOW DID INJURY OCCUR? Shot by assailant.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot by assailant.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. DATE 8-11-72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. NAME OF CEMETERY or CREMATORY St Luke Cemetery	
24C. LOCATION (City, town, or county) (State) Reisterstown, Md.		24D. DATE REC'D BY HEALTH DEPT. AUG 9 1972	
24E. NAME OF REGISTRAR Andrew W. Houston		24F. FUNERAL DIRECTOR Wm C March 928 E North Ave.	
24G. SIGNATURE Russell S. Fisher, M.D.		24H. DATE SIGNED 8-7-72	

N 862-1 3307

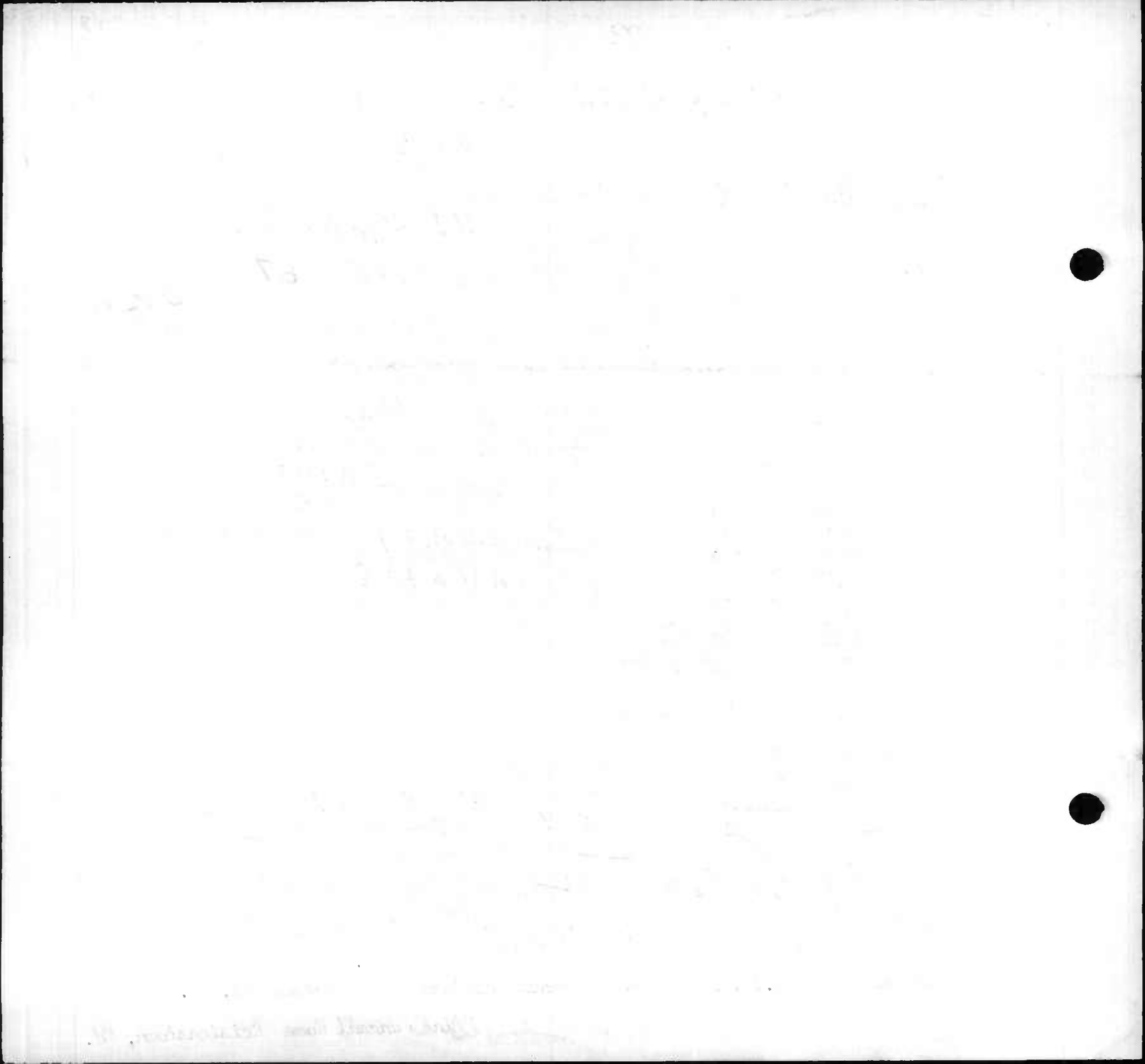
March Funeral Home
738 E 30th St.

CT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

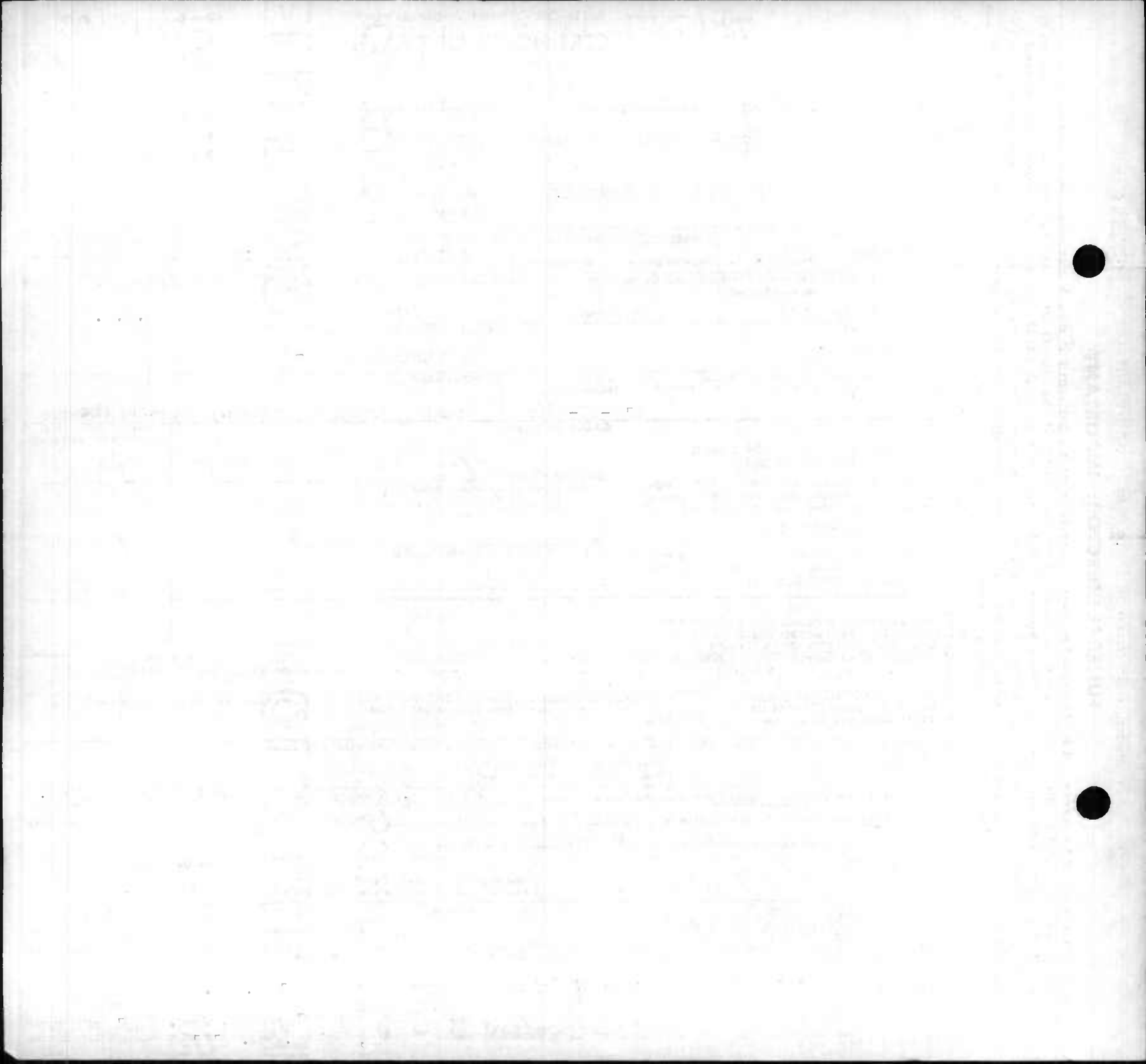
BALTIMORE CITY HEALTH DEPARTMENT		72 07592		X		72 07592	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DMHM			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		Barnes, Oden W.		Aug 9, 1972		3:48A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
North Charles General Hosp				Maryland 21136 5300			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
M		W.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4/15/05	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RETIRED.		SALESMAN.		Md.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William Oden Barnes (d)				Margaret Roderger (d)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		215-08-8309		Hosp. Chart			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				ACUTE MYOCARDIAL INFARCTION			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
				(B) CORONARY THROMBOSIS			
				(C) DIABETES			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8-8 1972 to 8-9 1972 that (I) (we) last saw the deceased alive on 8-9 1972 and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Joseph P. Gordon MD				8/9/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JOSEPH P. GORDON MD				2724 W. Charles St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Aug. 12, 72		Meadow Branch Cemetery		Westminster, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 10 1972		Sidney H. [Signature]		Eline Funeral Home		Reisterstown, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
72 07593		72 07593		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
RUTKOWSKI, Veronica		8/6/72		8:45 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
33 The Johns Hopkins Hospital		Maryland		2642	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		4328 Parkside Drive			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: Hours: Min.
Female	Cauc.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/1/19	53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife		at home		Ohio	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Joseph Sagan		Catherine -		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		218-03-6556		Frank Rutkowski (Husband) same as above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		3 YRS.	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		UNKNOWN.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
4/13/69.		BRAIN TUMOR		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 6 8:30 PM 19 72</u> to <u>Aug 6 8:45 PM 19 72</u> that (I) (we) last saw the deceased alive on <u>never</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
<u>Veronica Northrup</u>		8/6/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Veronica Northrup		601 N. BROADWAY, BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		8/10/72		Gardens of Faith Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 10 1972		Friday Rutkowski		Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 07594

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Samuel S. Cucina

2. DATE AND HOUR OF DEATH

August 7, 1972

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

43

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1433 South Hanover Street

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

March 20, 1897

9. AGE (In years
last birthday)

75

If Under 1 Yr.
Months: DaysIf Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Trailer

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Anthony Cucina

14. MOTHER'S MAIDEN NAME

Jennie LaRosa

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
215 03 3380

17. INFORMANT

Anthony Cucina

ADDRESS
1730 S. Charles Street
Balto., Md. 21230

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

Acute Coronary Occlusion

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerotic Cordis Vascular Disease

(B) DUE TO, OR AS A CONSEQUENCE OF:

Chronic obstructive Pulmonary Disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

instantaneous

years

years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 1970 to Aug. 7 1972
that (I) (we) last saw the deceased alive on Aug. 7 1972 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE


Attending
Phys.Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

8-8-72

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

DEGREE

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-11-72

24C. NAME of CEMETERY or CREMATORY

Meadowridge Memorial Park

24D. LOCATION

(City, town, or county)

Howard County, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

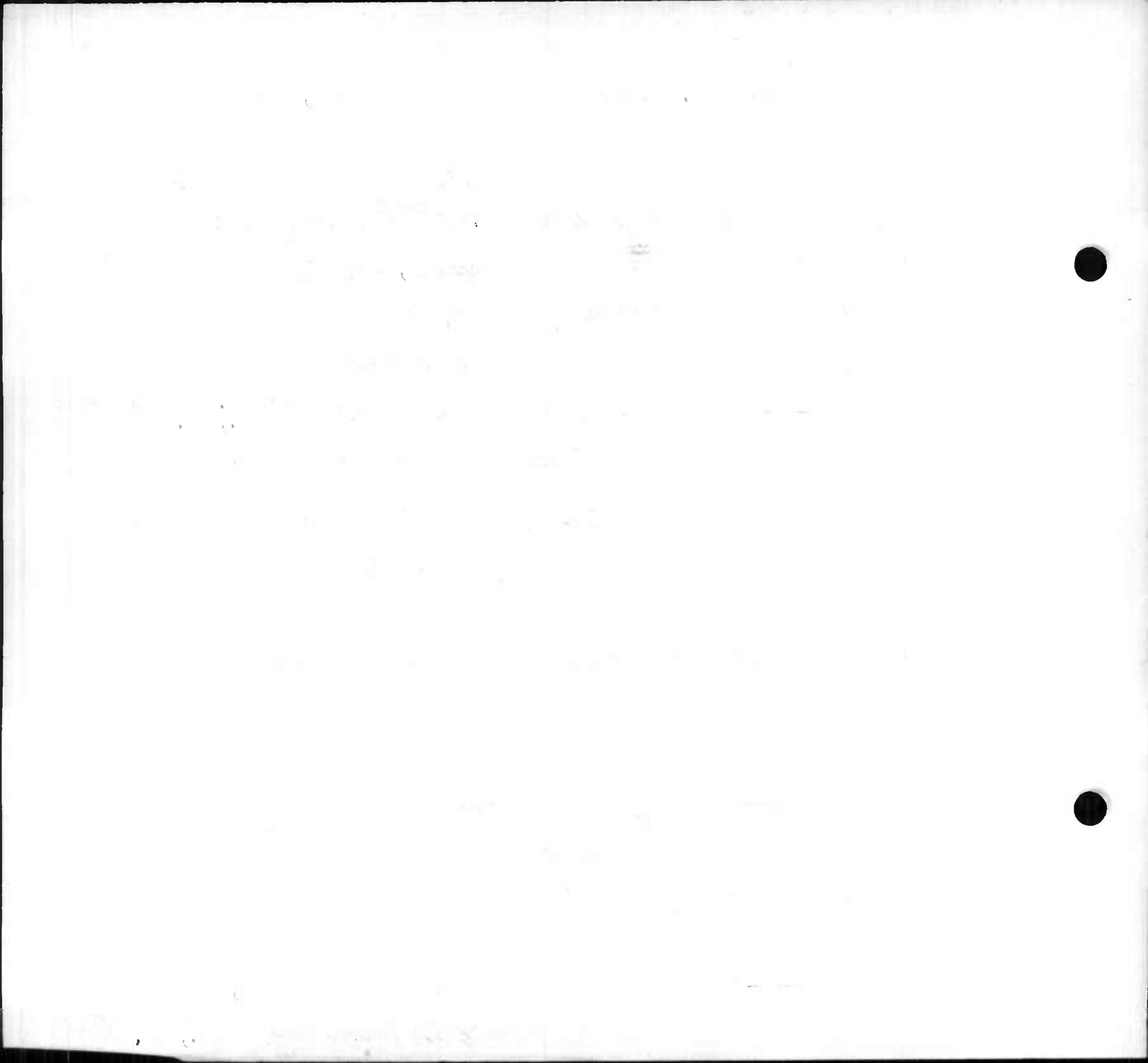
AUG 10 1972

25B. NAME OF REGISTRAR

Anthony Cucina

25C. FUNERAL DIRECTOR

130 East Ford Avenue
Balto., Md. 21220



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

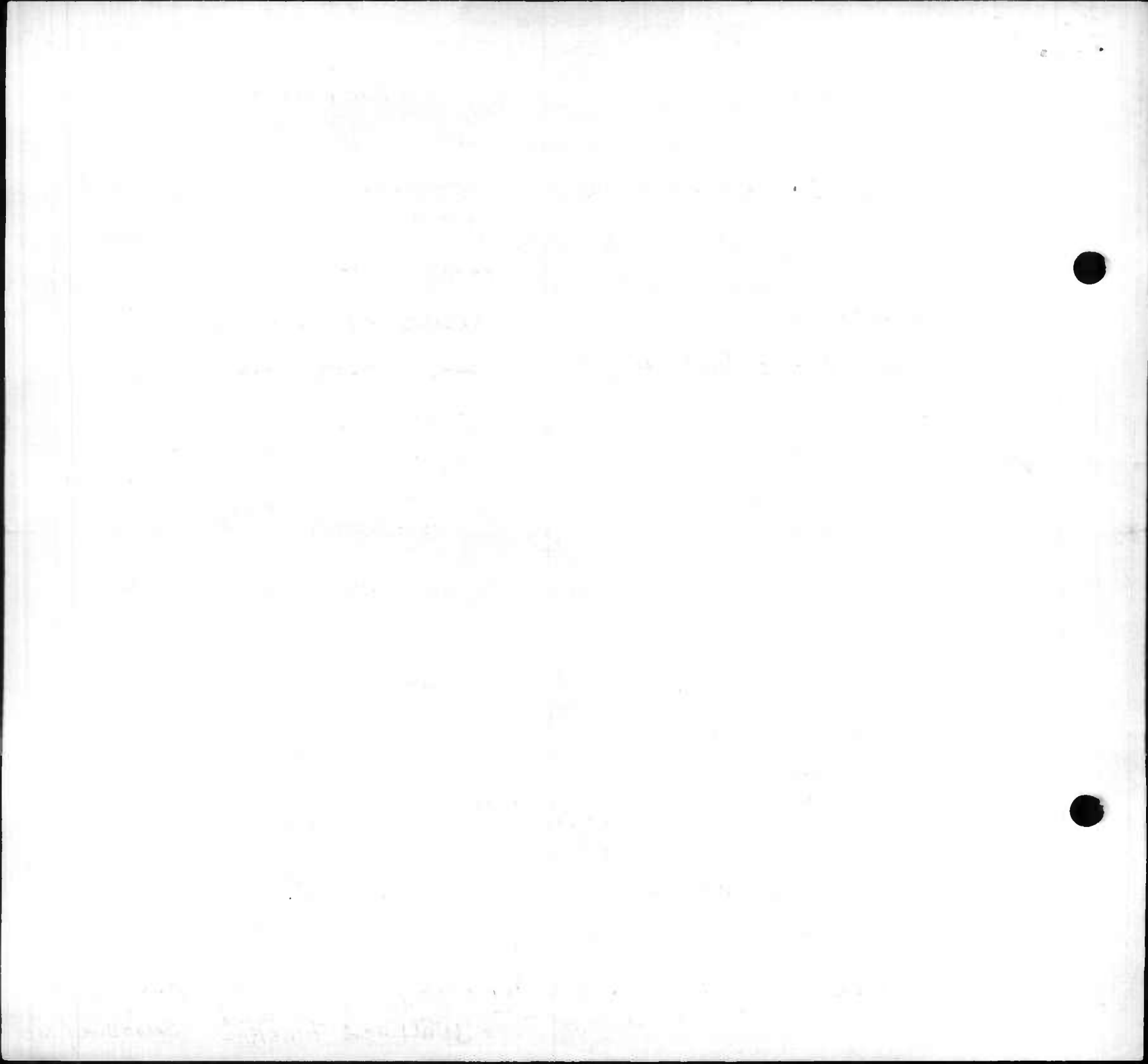
BALTIMORE CITY HEALTH DEPARTMENT 72 07595 CERTIFICATE OF DEATH				REG. NO. 72 07595 STATE OF MARYLAND - DUMFRIES	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>BONSAL, McJOURN</u>		2. DATE AND HOUR OF DEATH <u>8-9-72 4:30 AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Church Home & Hospital Baltimore MD. 21231</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>602</u>	
5. SEX <u>M</u>		6. RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>6-17-1900</u>		9. AGE (In years last birthday) <u>72</u>		10. UNDER 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk (Retail)</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Food Store</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American</u>		13. FATHER'S NAME <u>George Bonsal</u>		14. MOTHER'S MAIDEN NAME <u>BERTHA FRANK</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>217-09-8126</u>		17. INFORMANT <u>Charles (wife)</u> ADDRESS	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF: <u>with Ventricular Fibrillation</u></p> <p>(B) <u>due to Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <u>Stable Post resuscitation & Vent. Fibrillation on 8/7/72</u></p> </div> </div>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>8/7/72</u> 19 to <u>8/9/72</u> 19 that (I) (we) last saw the deceased alive on <u>8/8/72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>McJourn Siddy MD</u>				23B. DATE SIGNED <u>8/9/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>M. YOUSUF SIDDIQUI MD.</u>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>8/12/72</u>		<u>Balto. Cemetery</u>	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.			
<u>North Ave. Balto. Md.</u>		<u>AUG 10 1972</u>			
25A. NAME OF REGISTRAR		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<u>Andrew Houston</u>		<u>Andrew Houston</u>		<u>2332-34 Jefferson St</u>	

is not a page 200

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 07596		72 07596	
BIRTH NO.		72 07596		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) GARY SULLIVAN		2. DATE AND HOUR OF DEATH AUG 1, 1972 9:45 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND HOSP.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY WICOMICO C. CITY OR TOWN SALISBURY D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER RFD 4			
5. SEX M	6. RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 20 1955	9. AGE (In years last birthday) 17	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SALISBURY, MARYLAND	
13. FATHER'S NAME CHARLES SULLIVAN SR.		14. MOTHER'S MAIDEN NAME BETTY LOWE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT CHART ADDRESS	
18. 5-40-01 CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASPIRATION		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RUPTURED INNOMINATE ARTERY TO TRACHEOSTOMY		15 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) PNEUMONITIS, DIFFUSE DUE TO, OR AS A CONSEQUENCE OF: RUPTURED APPENDIX, FASCITIS		1 hr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 7/18/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED APPENDECTOMY, DRAINAGE		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/18/72 19 to 8/1/72 19 that (I) (we) lost saw the deceased alive on 8/1/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George H. Brouillet Jr MD		23B. DATE SIGNED 8/1/72		23C. PHYSICIAN'S NAME (Type) GEORGE H. BROUILLET JR M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-7-72		24C. NAME OF CEMETERY OR CREMATORY PARSONS CEMETERY	
24D. LOCATION (City, town, or county) SALISBURY - MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 10 1972			
25B. NAME OF REGISTRAR Lidney Weston		25C. FUNERAL DIRECTOR WALLACE FUNERAL HOME ADDRESS SALISBURY MD.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07597

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07597

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Rose Loretto Johnson

2. DATE AND HOUR OF DEATH

August 2, 1972

10 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 529 Harwood Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

Baltimore,

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

529 Harwood Ave.

5. SEX

F

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

April 15, '88

9. AGE (In years
last birthday)

84

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Kehoe

14. MOTHER'S MAIDEN NAME

Katherine

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

220 50 4825

17. INFORMANT

Mr. J. LeGrand Johnson

ADDRESS

Above

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

6 mos

6+ mos

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

3/25/72

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED
Exploration for colon cancer

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov 18, 1971 to Aug 2, 1972,
that (I) (we) last saw the deceased alive on July 31, 1972 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Frederick J. Vollmer MD

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

8-2-72

23C. PHYSICIAN'S
NAME (Type)

Frederick J. Vollmer

23D. ADDRESS

6100 York Rd., Baltimore, Md. 21212

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/5/72

24C. NAME OF CEMETERY or CREMATORY

New cathedral Cem.

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 10 1972

25B. NAME OF REGISTRAR

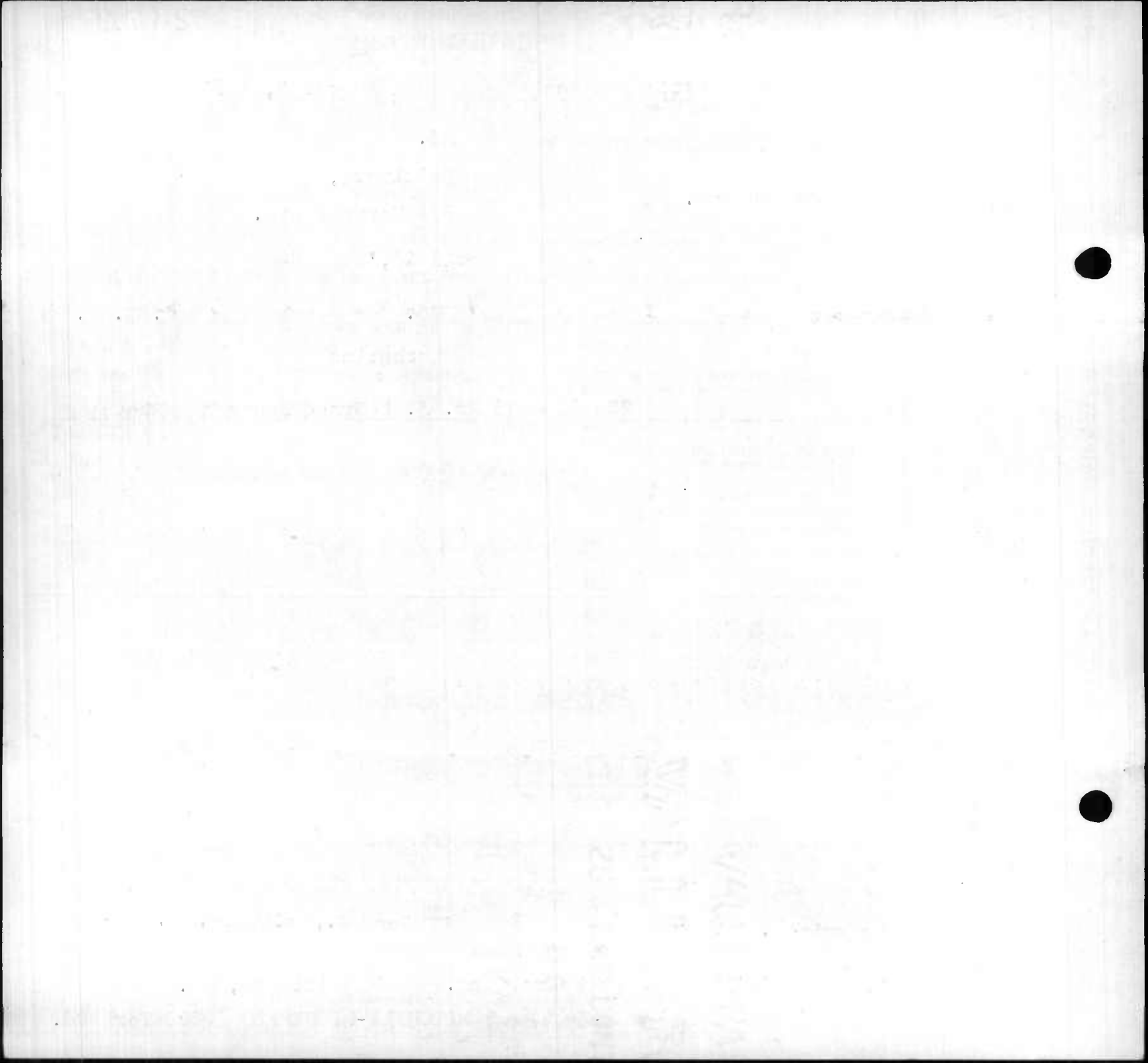
Frederick J. Vollmer

25C. FUNERAL DIRECTOR

MITCHELL-WIEDEFELD

ADDRESS

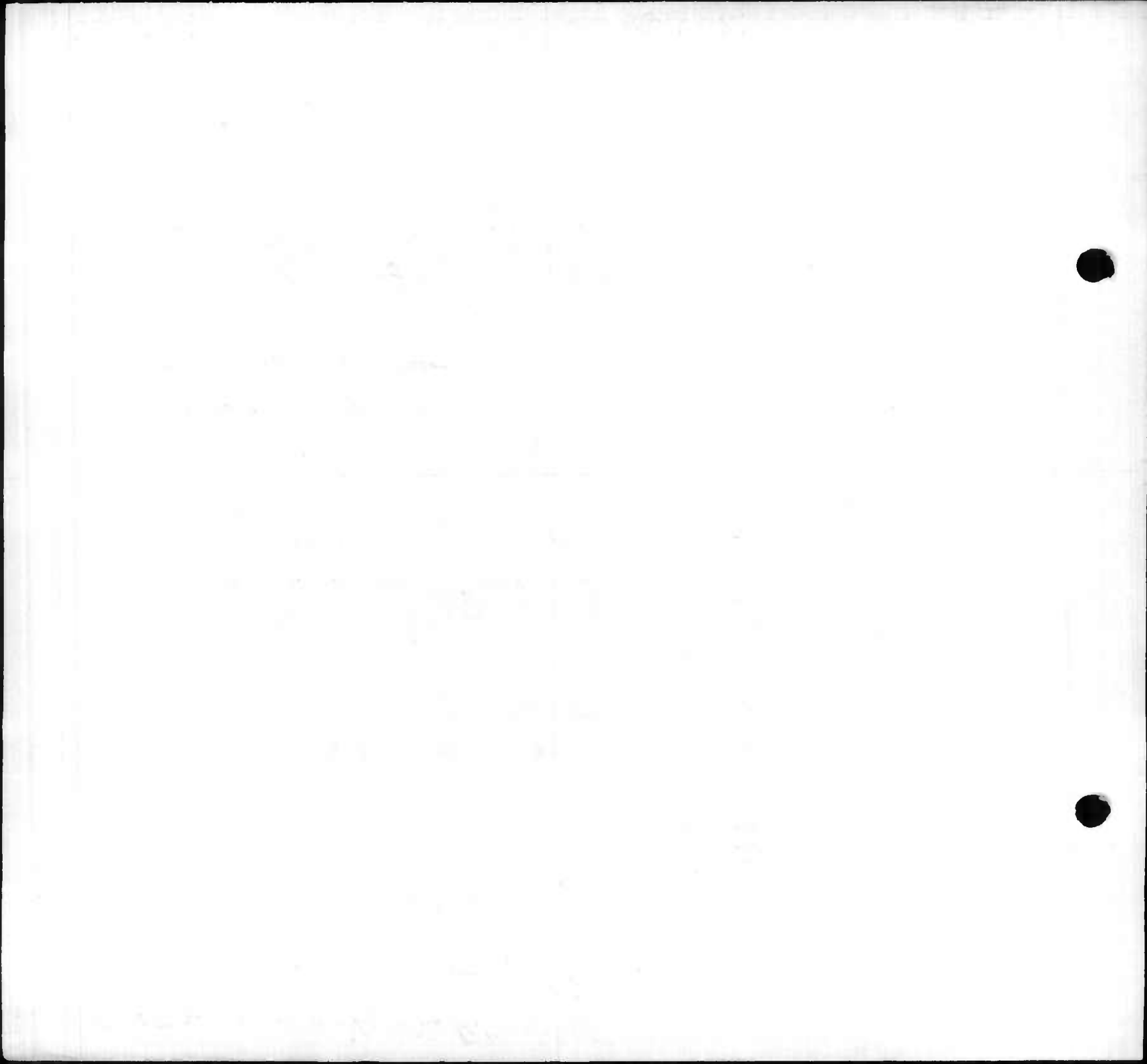
6500 York Rd.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07598 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				72 07598 STATE OF MARYLAND-DHMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Anna Barrett</i>		2. DATE AND HOUR OF DEATH <i>8-8-72 5:40 PM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>SOUTH BALTIMORE GEN. HOSP.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALTIMORE</i> C. CITY OR TOWN <i>Baltimore MD.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2102</i>		
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-17-92</i>	9. AGE (in years last birthday) <i>79</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
13. FATHER'S NAME <i>GEORGE WASHINGTON ZAPP</i>			14. MOTHER'S MAIDEN NAME <i>Whitney - MARIE KIMMEL</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family - SAKÉ</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <i>Pulmonary embolism, blood</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>atherosclerotic heart disease</i> (B) <i>diabetes mellitus</i> DUE TO, OR AS A CONSEQUENCE OF: <i>non specific gastroenteritis</i> (C) <i>hemorrhagic gastritis</i>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Carlo N. Potalinghug</i> <i>Carlo N. Potalinghug</i> DEGREE				23B. DATE SIGNED <i>8-8-72 5:45</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <i>SBGA</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>8-12-72</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Olivet</i>	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR <i>Baltimore</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 10 1972</i>		25B. NAME OF REGISTRAR <i>Anthony Johnson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>130 E. Fort Ave.</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07599

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07599

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Huth, Lillian

2. DATE AND HOUR OF DEATH

8/7/72

4:10 pm M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

3210 Ramona Ave. 21213

5. SEX

F

6. RACE

Cauc.

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

4-11-84

9. AGE (In years
lost birthday)

88

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None Given

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

EDWARD LOEFFLER

14. MOTHER'S MAIDEN NAME

CAROLINE FRYER

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

2120546370

17. INFORMANT

Daughter, Mrs. Mildred Garrett

ADDRESS

3210 Ramona Ave

18. ~~E880N~~DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of death, such as heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION, if any

CAUSE OF DEATH

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Brain Stem Contusion

(B) OCCUPITAL SKULL FX, Compound

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

~11:30 am 8/7/72

~11:30 am 8/7/72

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

8/7/72

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Pao. (L) Subdural Hematoma

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

~11:30 am 8/7/72

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home (yard)

21E. INJURY OCCURRED
While At Work ☐ Not While
At Work ☒21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

3210 Ramona Ave. 21213

21F. HOW DID INJURY OCCUR?

Fell down steps

22. I certify that (I) (this hospital) attended the deceased from 8/7/72 19 to 8/7/72 19
that (I) (we) last saw the deceased alive on 8/7/72 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Randolph O. George, M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8/7/72

23C. PHYSICIAN'S
NAME (Type)

RANDOLPH O. GEORGE, M.D.

23D. ADDRESS

Johns Hopkins Hospital, Balto. 21205

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

10 AUG 72

24C. NAME OF CEMETERY OR CREMATORY

PARKWOOD CEMETERY

24D. LOCATION
(City, town, or county)

BALTA. CO., MD.

25A. DATE REC'D BY HEALTH DEPT.

AUG 10 1972

25B. NAME OF REGISTRAR

Sidney Johnston

25C. FUNERAL DIRECTOR

AMERICAN FUNERAL HOME, BALTA, MD. 21206

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

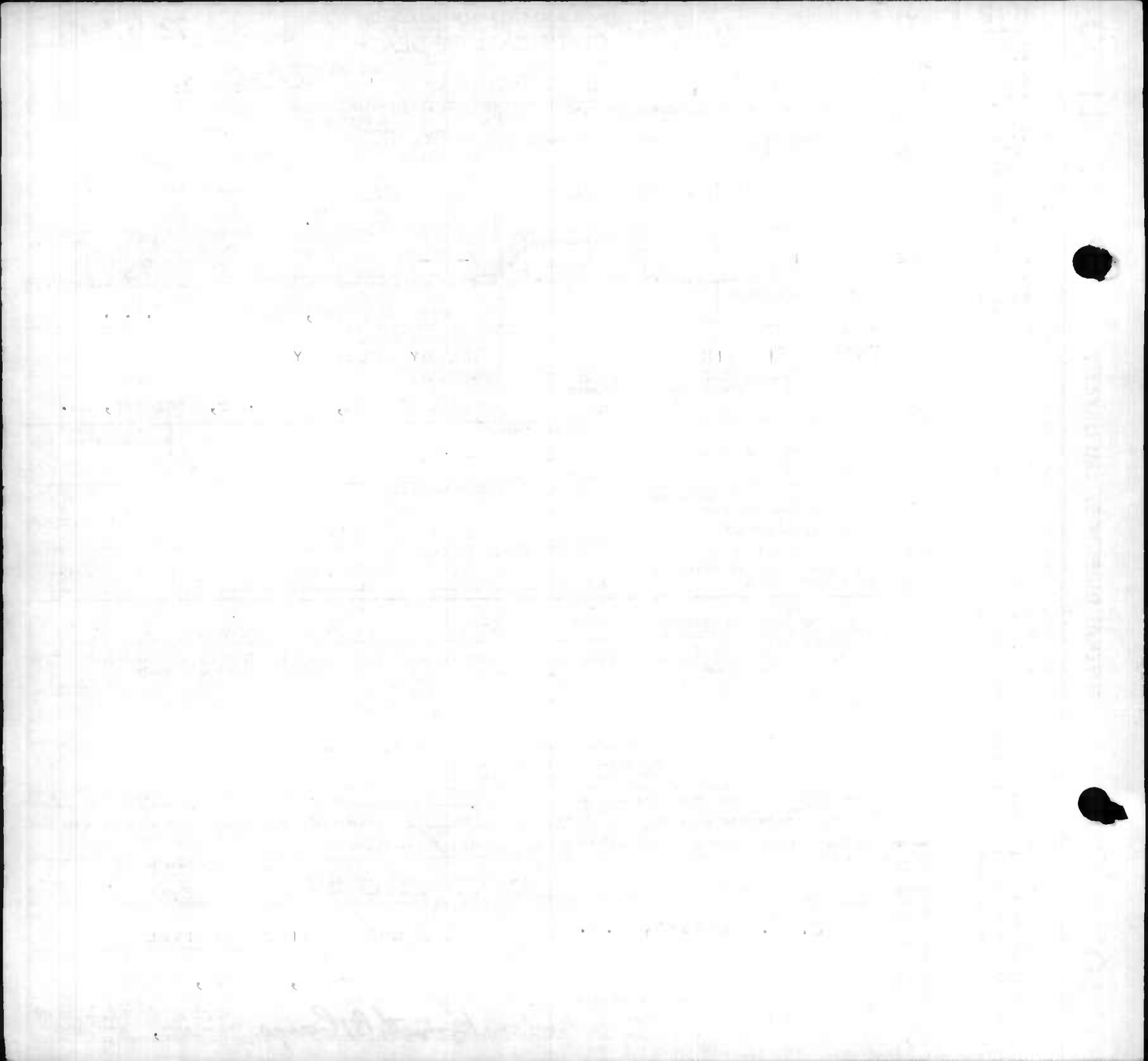
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07600		REG. NO. 72 07600	
BIRTH NO. 72 07600				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Anna H. Nodolny				2. DATE AND HOUR OF DEATH August 4 1972 4:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home Hospital 35				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland 21231 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 508 S. Lakewood Avenue			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 22 1913		9. AGE (In years last birthday) 58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10B. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Sisolak				14. MOTHER'S MAIDEN NAME Elizabeth Zisko			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 215-32-0021		17. INFORMANT John Nodolny 508 S Lakewood Avenue	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION A.S.E.D.D. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). MIXED EMER				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hr. 1 hr. 1 yr.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from MARCH 16 1971 to APRIL 4 1972 , that (I) (we) last saw the deceased alive on 3/18 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. B. Highstein						23B. DATE SIGNED 8/17/72	
23C. PHYSICIAN'S NAME (Type) Dr. B. Highstein				23D. ADDRESS 121 S. Highland Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-8-72		24C. NAME OF CEMETERY or CREMATORY St Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1972		25B. NAME OF REGISTRAR Ardisy...		25C. FUNERAL DIRECTOR William Fialkowski		ADDRESS 2007 Eastern Avenue	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

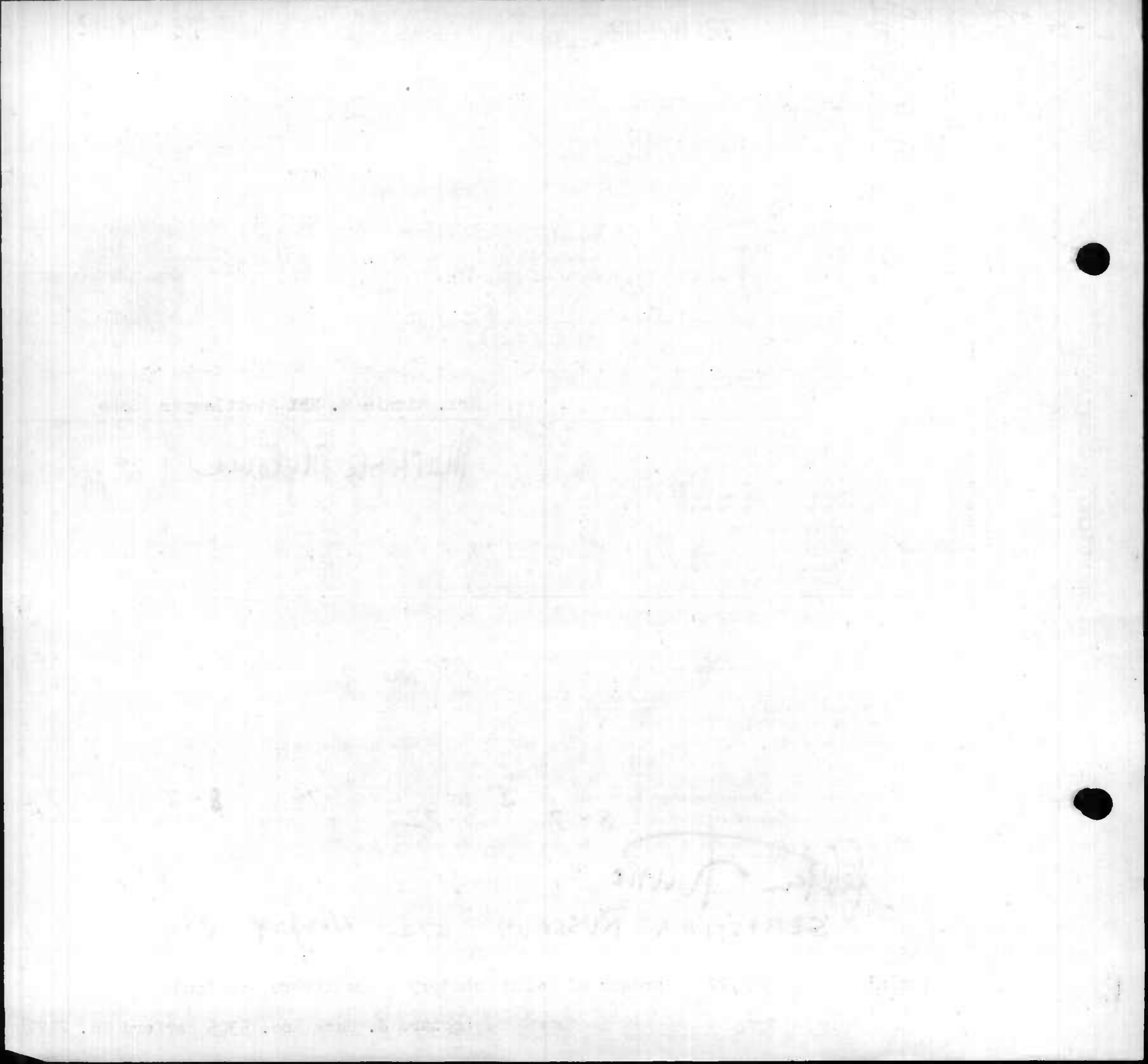
BALTIMORE CITY HEALTH DEPARTMENT											
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. <i>72 07601</i></p> <p>1. NAME OF DECEASED (Type or Print) <i>Havre de Grace, Md.</i></p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>REG. NO. <i>72 07601</i></p> </div> </div>											
<p>2. DATE AND HOUR OF DEATH <i>8-7-72 8:37 PM</i></p>											
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><i>THE JOHNS HOPKINS HOSPITAL</i></p>						<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <i>MARYLAND</i> B. COUNTY <i>HARFORD</i></p> <p>C. CITY OR TOWN <i>ABERDEEN</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER <i>406 CLOVER ST.</i></p>					
<p>5. SEX MALE</p>		<p>6. RACE WHITE</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <i>7-29-72</i></p>		<p>9. AGE (In years last birthday) <i>9</i></p>		<p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i></p>				<p>10B. KIND OF BUSINESS OR INDUSTRY</p>				<p>11. BIRTHPLACE (State or foreign country) <i>Havre de Grace, Maryland</i></p>		<p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p>	
<p>13. FATHER'S NAME <i>THOMAS FICKLIN</i></p>						<p>14. MOTHER'S MAIDEN NAME <i>SHERRY HOLLOWAY</i></p>					
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i></p>				<p>16. SOCIAL SECURITY NO. <i>None</i></p>		<p>17. INFORMANT ADDRESS <i>Thomas Ficklin, 406 Clover, Aberdeen, Md.</i></p>					
<p>18. <i>038.8 1746.1</i> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>CARDIOVASCULAR Shock</i></p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Sepsis - ? Bacterial</i></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Systemic Acidosis</i></p> <p>(C) <i>Transposition of Great Arteries</i></p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>11 hours</i> <i>11 hours</i> <i>11 hours</i> <i>11 days</i></p>											
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Transposition of Great Arteries</i></p>											
<p>19A. DATE OF OPERATION <i>Lapostomy 7/30</i></p>				<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Transposition of Great</i></p>				<p>20A. AUTOPSY? (Yes or No) <i>Yes</i></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH? <i>No</i></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>				<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>				<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>				<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>				<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from <i>7/30</i> 19 <i>72</i> to <i>Aug 7</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>Aug 7</i> 19 <i>72</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>											
<p>23A. SIGNATURE <i>J. E. Graeber M.D.</i></p>								<p>23B. DATE SIGNED <i>Aug 7, 1972</i></p>			
<p>23C. PHYSICIAN'S NAME (Type) <i>J. E. GRAEBER, M.D.</i></p>								<p>23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i></p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i></p>				<p>24B. DATE <i>9 Aug 72</i></p>		<p>24C. NAME OF CEMETERY or CREMATORY <i>Spesutia Cemetery</i></p>		<p>24D. LOCATION (City, town, or county) (State) <i>Perryman, Harford, Maryland</i></p>			
<p>25A. DATE REC'D BY HEALTH DEPT. <i>AUG 10 1972</i></p>				<p>25B. NAME OF REGISTRAR <i>Andrew J. ...</i></p>				<p>25C. FUNERAL DIRECTOR <i>Kenneth B. ...</i></p>			
<p>ADDRESS <i>Tarring Funeral Home, Aberdeen, Maryland</i></p>											



FUNERAL DIRECTOR: IMPORTANT

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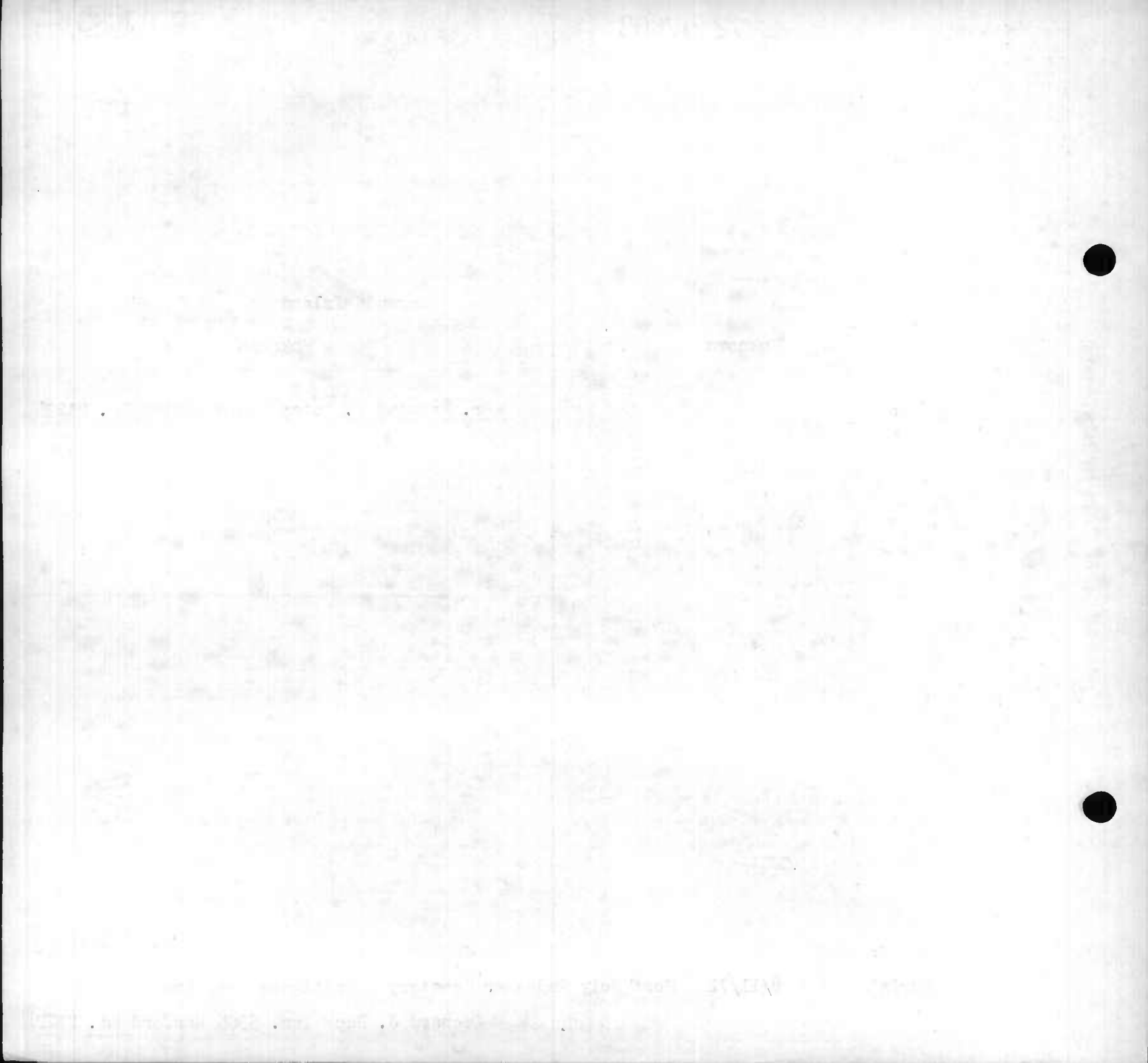
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 07602</u>
72 07602				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Stottlemeyer, John Herndon Sr.</u>		
2. DATE AND HOUR OF DEATH <u>Aug 8, 1972</u> <u>8:45 P.M.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore City</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>5110 Harford Road</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>5110 Harford Road</u>		E. STREET AND NUMBER <u>5110 Harford Road</u>		
5. SEX <u>Male</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 8, 1914</u>	9. AGE (In years last birthday) <u>58 yrs</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam Fitter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Labor</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Edward Stottlemeyer</u>		
14. MOTHER'S MAIDEN NAME <u>Carrie Mignon Carson</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>216-09-4064</u>		17. INFORMANT <u>Mrs. Minnie M. Stottlemeyer</u>		
18. CAUSE OF DEATH <u>Multiple Myeloma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) _____		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION <u>8-7-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>No</u>		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>2-10-70</u> to <u>8-7-72</u> that (I) (we) last saw the deceased alive on <u>8-7-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Sebastian Russo</u>		23B. DATE SIGNED <u>8/8/72</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>SEBASTIAN RUSSO</u>		23D. ADDRESS <u>5122 Harford Rd</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/11/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1972</u>		
25B. NAME OF REGISTRAR <u>Sebastian Russo</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Buck Inc.</u>		
25D. ADDRESS <u>5305 Harford Rd. 21214</u>				



FUNERAL DIRECTOR: IMPORTANT

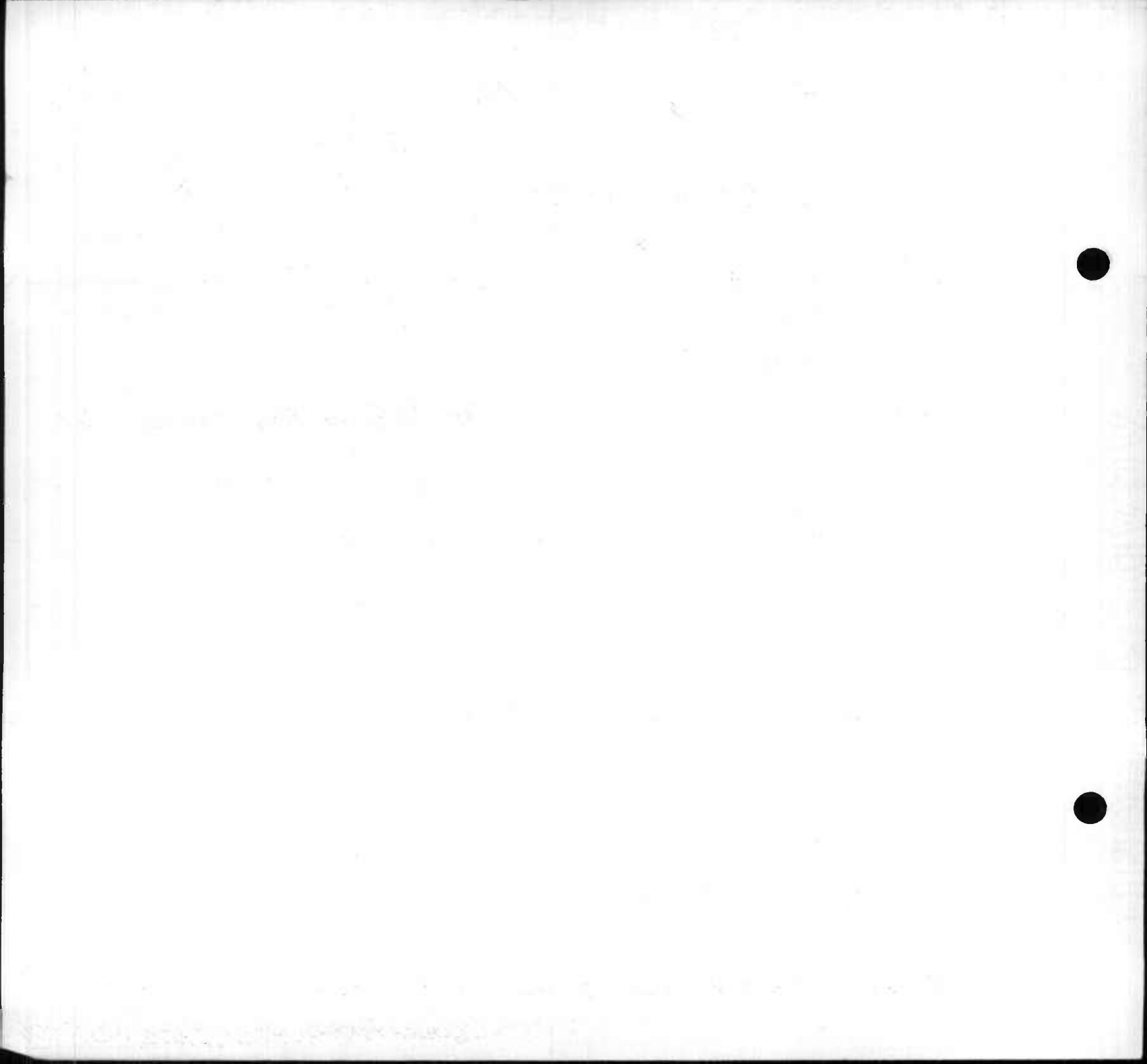
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BALTIMORE CITY HEALTH DEPARTMENT				72 07603		72 07603	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>ORMAND D. TATEM</u>				2. DATE AND HOUR OF DEATH <u>AUG 8 1972</u> <u>11:15P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 LONG GREEN NURSING HOME</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2631</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4431 RASPE AVE</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-29-92</u>	9. AGE (In years last birthday) <u>80</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>STREET CAR DRIVER</u>		11. BIRTHPLACE (State or foreign country) <u>Bermuda Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-2688</u>		17. INFORMANT <u>Mr. Raymond O. Tatem 8407A Ninley Dr. 21234</u>			
18. <u>433.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CEREBRAL VASCULAR OCCLUSION</u> (B) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF: <u>? yes</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 Hrs</u>	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7-26 1972</u> to <u>8-8 1972</u> , that (I) (we) last saw the deceased alive on <u>7-26 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>FREDERICK J. VOLLMER M.D.</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>8-8-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>FREDERICK J. VOLLMER M.D.</u>				23D. ADDRESS <u>6100 YORK RD BALTIMORE MD 21212</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/11/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Most Holy Redeemer Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1972</u>		25B. NAME OF REGISTRAR <u>Sidney J. [unclear]</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. 5305 Harford Rd. 21214</u>		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 07604 CERTIFICATE OF DEATH				REG. NO. 72 07604	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MAGUIRE, IRMA M.		2. DATE AND HOUR OF DEATH 8-8-72 7:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2757		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION NORTH CHARLES GEN. HOSP.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-16	9. AGE (in years last birthday) 55	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN FOSTER		14. MOTHER'S MAIDEN NAME LULA MACKERT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT JOHN MCGUIRE 3009 PINEWOOD 21214	
18. 123.01 CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF:			
		(B) OVARIAN MALIGNANCY DUE TO, OR AS A CONSEQUENCE OF:			
		(C) METASTASIS Viscera + Lungs			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8-8-72 to 8-8-72 that (I) (we) last saw the deceased alive on 8-8-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Ruperto Manankil MD		23B. DATE SIGNED 8-8-72		23C. PHYSICIAN'S NAME (Type) RUPERTO MANANKIL MD	
23D. ADDRESS NORTH CHARLES GEN HOSP BALTO		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10 AUG 72	
24C. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL PK.		24D. LOCATION (City, town, or county) (State) BALTO. CO., MD. 21204		25A. DATE REC'D BY HEALTH DEPT. AUG 10 1972	
25B. NAME OF REGISTRAR Sidney W. Boston		25C. FUNERAL DIRECTOR CECILIA FEDERAL HOME, BALTO, MD. 21206		25D. ADDRESS	

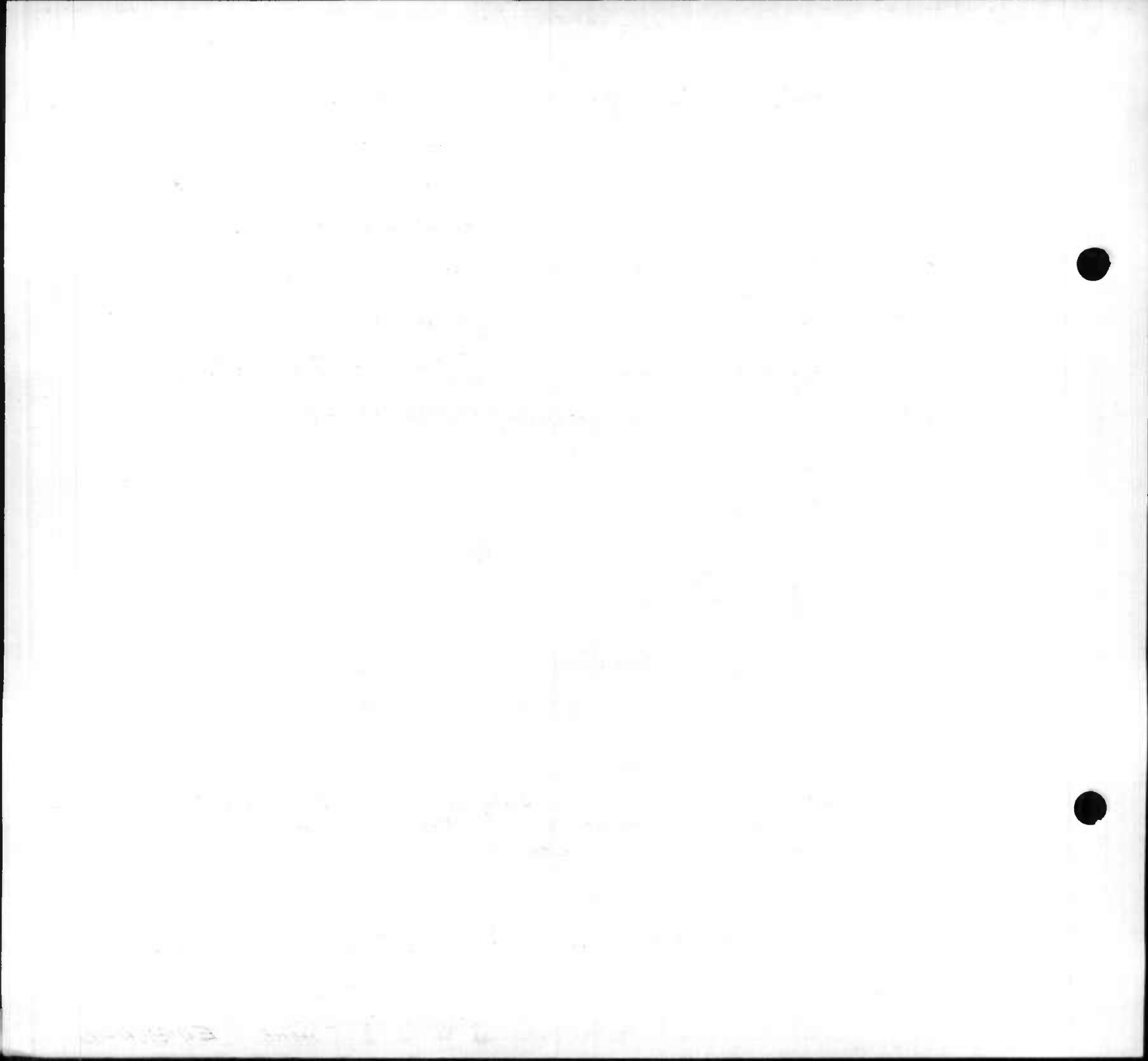


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07605 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 07605

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HERBERT MARY K.		2. DATE AND HOUR OF DEATH 8-9-72 12:58 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 91 MONTEBELLO STATE HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 1102 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 524 N. CHARLES ST.	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-30-93	9. AGE (In years last birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ALFRED KENNEDY				14. MOTHER'S MAIDEN NAME JOANNA FLAHERTY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UN KNOWN		16. SOCIAL SECURITY NO. 217-22-3679A		17. INFORMANT PATIENTS CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.41 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH Cerebrovascular accident; old and recent with bilateral involvement (A) IMMEDIATE CAUSE Recent with bilateral involvement DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease ATRIAL Fibrillation chronic; cardiomegaly 1 year (B) CLASS III-A: myocardial injury age unknown DUE TO, OR AS A CONSEQUENCE OF: RECURRENT URINARY INFECTION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 mos + 14 days				19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). History of Pneumonia	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from July 8, 1971 to AUGUST 9, 1972 that (we) lost saw the deceased alive on AUGUST 9, 1972 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rhodora C. Tumanon M.D.				23B. DATE SIGNED 8-9-72	
23C. PHYSICIAN'S NAME (Type) RHODORA C. TUMANON M.D.				23D. ADDRESS Montebello STATE HOSPITAL 2201 ARBONNE DRIVE BALT. MD. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-12-1972		24C. NAME of CEMETERY or CREMATORY NEW CATHEDRAL CEM BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1972		25B. NAME OF REGISTRAR Sidney [Signature]		25C. FUNERAL DIRECTOR WEBER FUNERAL HOME EDWARDS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07606

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07606

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MICHAEL BERNACKI

2. DATE AND HOUR OF DEATH

AUGUST 7, 1972

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

6203 EVERALL AVE.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MD. BALTIMORE 2734

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

6203 EVERALL AVE.

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

9-15-1911

9. AGE (In years
last birthday)

60

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CONSTRUCTION

10B. KIND OF BUSINESS OR INDUSTRY

STANFORD CO.

11. BIRTHPLACE (State or foreign country)

POLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

ANTHONY BERNACKI

14. MOTHER'S MAIDEN NAME

MARY TRUSZKOWSKA

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

216-30-1314

17. INFORMANT

STEPHANIE BERNACKI 6203 EVERALL AVE

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

9 mos

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At
Work ☐Not White
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-6-72 19 to 8-7 1972
that (I) (we) last saw the deceased alive on 8-7-72 19 and that (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Theodore T. Zygorski

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

8-8-72

23C. PHYSICIAN'S
NAME (Type)

T. W. ZYGORSKI

23D. ADDRESS

429 S Chester

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

8-12-72

24C. NAME OF CEMETERY or CREMATORY

HOLY ROSARY CEMETERY DUNDALK

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 10 1972

25B. NAME OF REGISTRAR

Anthony W. Zygorski

25C. FUNERAL DIRECTOR

M. WEBER & SONS INC. ADDRESS 401 S CHESTER

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. STATE OF MARYLAND-DEATH

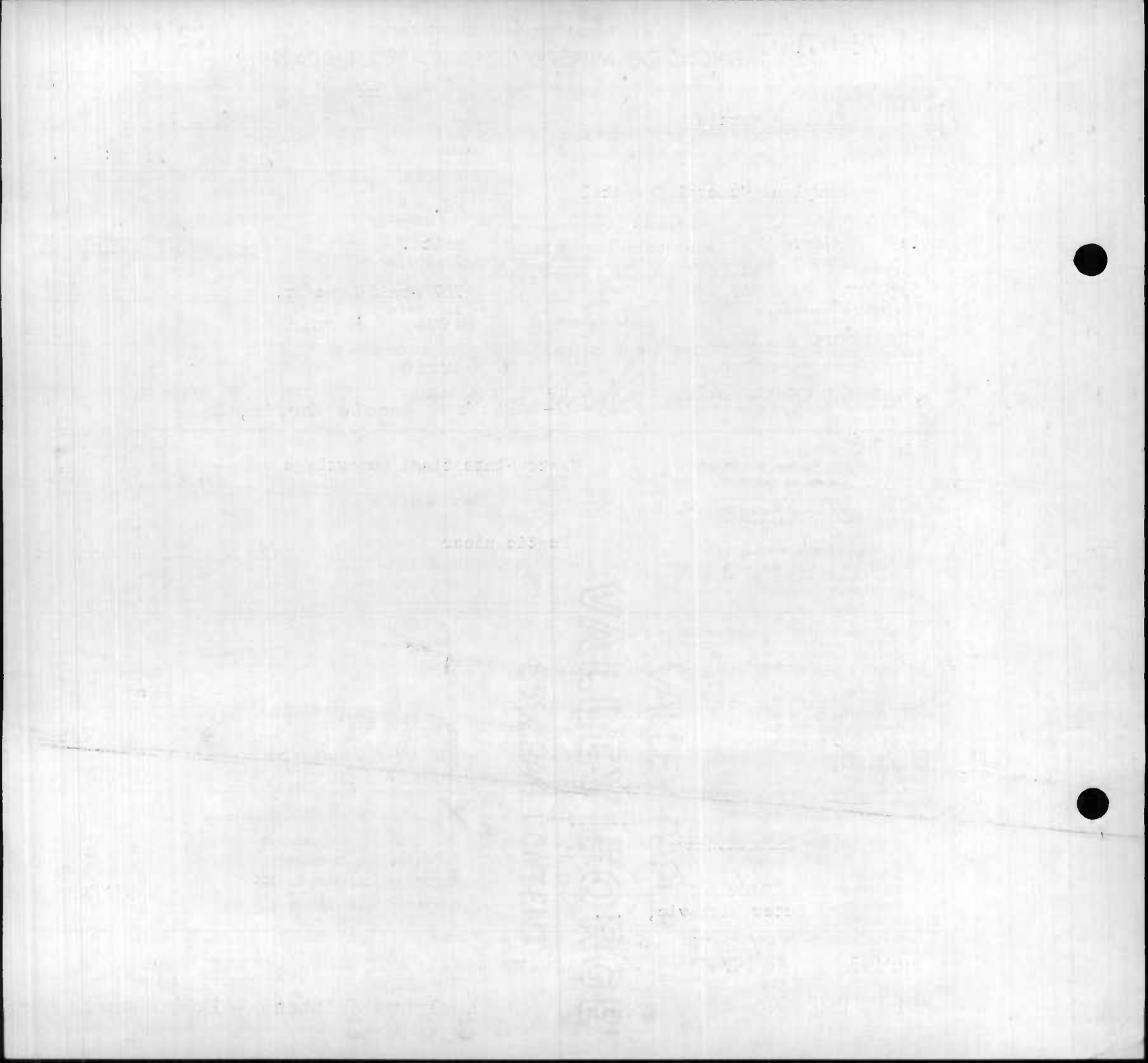
BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Martin		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 8 9 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 9 72 1:15 a. M.	
6. SEX male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1301	
9. DATE OF BIRTH 5/5/07		10. AGE (In years lost birthday) 65	
11. BIRTHPLACE (State or foreign country) Greenboro N C		12. CITIZEN OF WHAT COUNTRY? A	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Carrie	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 239071694	
18. INFORMANT Mrs Jessie Martin, Same		ADDRESS	

19. 533.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gastro-intestinal hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Peptic ulcer		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					

20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/9/72					

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/72		24C. NAME of CEMETERY or CREMATORY MT Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1972		25B. NAME OF REGISTRAR Lidny		25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W north Ave	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07608	
CERTIFICATE OF DEATH				REG. NO. 72 07608	
BIRTH NO. 72 07608		1. NAME OF DECEASED (Type or Print) <u>JENKINS, SAMUEL</u>			
2. DATE AND HOUR OF DEATH <u>5 August 6.30 A.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md</u> B. COUNTY <u>1002</u>		5. SEX <u>M</u> 6. RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>827 N Aisquith Street 21202</u>		F. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Church Home & Hospital</u> <u>100 N Broadway Baltimore</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed ? TRUCK DRIVER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	
13. FATHER'S NAME <u>JOHN SENKINS</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE (?)</u>		12. CITIZEN OF WHAT COUNTRY? <u>Ameri</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>21709 8806</u>		17. INFORMANT ADDRESS <u>Mrs. Mary Stevens 827 N. Aisquith St.</u>	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiopulmonary arrest</u>		<u>15 min</u>	
ANTECEDENT CAUSES		(B) <u>chron. renal failure</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>3 months?</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>Multiple Myeloma</u>		<u>6 months?</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/9/1972</u> to <u>8/5/1972</u> that (I) (we) last saw the deceased alive on <u>8/5/1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>8/5/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>L. P. ADAMAS</u>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<u>Burial</u>		<u>8/10/72</u>		<u>St. Calvary Cem.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR ADDRESS <u>1118 TO FUNERAL HOME</u>	

1872 11 11

1
F-430

72 07609

BALTIMORE CITY HEALTH DEPARTMENT

72 07609

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. ~~STATE OF MARYLAND~~ DE

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BELMON FLOOD		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1907 E. North Avenue		3. DATE PRONOUNCED DEAD Month Day Year August 7, 1972 Hour 6:23 P. M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Virginia B. COUNTY ✓ 43	
7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Suffolk	
9. DATE OF BIRTH 4-11-41	10. AGE (In years last birthday) 31 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Na		E. STREET AND NUMBER Rte. 3, Box 619	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Willie Flood	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		15. MOTHER'S MAIDEN NAME Maggie ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Willie Flood		ADDRESS 1316 N. Lugene Ave	

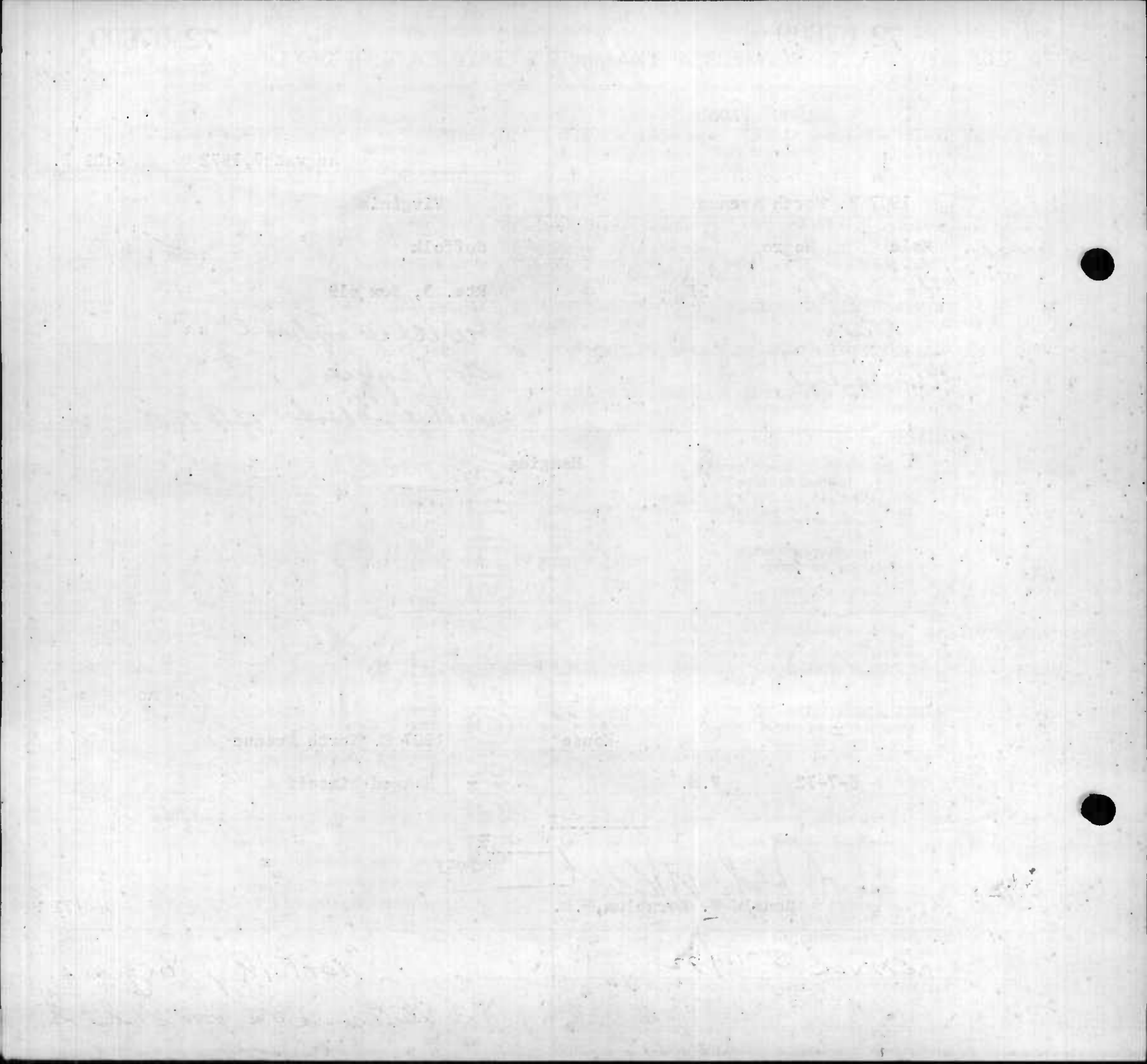
MEDICAL CERTIFICATION	19. E953X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Hanging (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				

20A. DATE OF OPERATION 8-7-72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1907 E. North Avenue	
22D. TIME OF INJURY (APPROX.) 8-7-72 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Hanged himself	

23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: **Ronald N. Kornblum, M.D.** Deputy CHIEF MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): **Ronald N. Kornblum, M.D.** ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED: **8/8/72**

24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL	24B. DATE 8-11-72	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State) Norfolk, Virginia
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1972	25B. NAME OF REGISTRAR Adrian W. Heston	25C. FUNERAL DIRECTOR The Elliott Funeral Home ADDRESS 1129 N. Caroline St.	



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A-450

72 07610

BALTIMORE CITY HEALTH DEPARTMENT

72 07610

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
STATE OF MARYLAND-DHMH

BIRTH NO.		1. NAME OF DECEASED (Type or Print) GLEN ALLEN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 3 1972 2 a M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1502	
6. SEX male	7. RACE negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 3/15/36		10. AGE (In years last birthday) 36		E. STREET AND NUMBER 1605 N. Fulton Ave.	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY U.S		13. FATHER'S NAME Walter Allen	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Martha Douglas	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Willie Mae Allen 1605 N. Fulton Ave.	
19. E965X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Gunshot wound of abdomen & right chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 1522 W. Saratoga St.	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 8-2-72 8:40 p m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. DATE SIGNED 8-3-72					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/72		24C. NAME of CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) (State) Mt. Winans, Maryland		24E. DATE REC'D BY HEALTH DEPT. AUG 10 1972		24F. NAME OF REGISTRAR Sidney B. Houston	
24G. FUNERAL DIRECTOR Charles A. Rice		24H. ADDRESS 1300 Eutaw Place			

873.9003606

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 07611	
CERTIFICATE OF DEATH		REG. NO. 72 07611	
STATE OF MARYLAND-DEME			
1. NAME OF DECEASED (Type or Print) EVA GRIFFIN		2. DATE AND HOUR OF DEATH 8-7-72 18-7-72 8 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH, HOME & Hospital 35		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE M.D. B. COUNTY U.S.A. C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 100 N Broadway	
5. SEX DF	6. RACE B	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-17-11
9. AGE (In years last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Government	
11. BIRTHPLACE (State or foreign country) M.D.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John GRIFFIN		14. MOTHER'S MAIDEN NAME Lutcha - German	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 216-74 2937	
17. INFORMANT John Griffin		ADDRESS 568 Radnor Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I ASHD, & hypertension ? II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 8-1-72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 8-1-1972 to 8-7-1972 that (I) (we) last saw the deceased alive on 7:30 PM 8-7-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Sajadi M.D. DEGREE SAJADI M.D. DEGREE 23B. DATE SIGNED 23C. PHYSICIAN'S NAME (Type) SAJADI 23D. ADDRESS CHURCH, HOME & Hospital 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 8/14/72 24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Cemetery 24D. LOCATION (City, town, or county) (State) Arbutus, Maryland 25A. DATE REC'D BY HEALTH DEPT. AUG 10 1972 25B. NAME OF REGISTRAR Charles A. Rice 25C. FUNERAL DIRECTOR Charles A. Rice ADDRESS 1300 Eutaw Place			

8/1/72
3603 N. Rogers Ave.
CT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07612

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ANNIE MOORE

2. DATE
OF
DEATHKnown ☐ Month Day Year HourEstimated ☐

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
OR INSTITUTION ADDRESS OR LOCATION)

2202 Brookfield Avenue

3. DATE
PRONOUNCED DEAD

Month Day Year Hour

August 2, 1972 12:10 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

1302

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

9/15/1901

10. AGE (In years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2202 Brookfield Avenue

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Hall

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Elizabeth

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

Shelley Anne Brookfield

2202 ADDRESS

19.

412.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Marvin Platt, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/2/72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/5/72

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county) (State)

Anne Arundel Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 10 1972

25B. NAME OF REGISTRAR

Sidney L. ...

25C. FUNERAL DIRECTOR

Marshall W. Jones, Jr.

ADDRESS

1735 Hayfield Ave

11/15/101

11/15/101

11/15/101

11/15/101

11/15/101

11/15/101

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07613		BALTIMORE CITY HEALTH DEPARTMENT		72 07613	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Florence Dunn		August 5, 1972 3 AM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE			
Full Name of Hospital or Institution (If not in hospital or institution, give street address or location)		C. CITY OR TOWN			
Midtown Home		Baltimore			
808 Saint Paul St Balt MD		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Female Negro		8. DATE OF BIRTH		9. AGE (In years last birthday)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		20. DATE OF OPERATION		21. CONDITION FOR WHICH OPERATION WAS PERFORMED	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		22. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		23. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
ANTECEDENT CAUSES		24. TIME OF INJURY (Month (Day) (Year) (Hour) (Approx.)		25. INJURY OCCURRED	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		27. HOW DID INJURY OCCUR?	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		28. AUTOPSY? (Yes or No)		29. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
30. I certify that (I) (this hospital) attended the deceased from _____ 19 ____ to _____ 19 ____ that (I) (we) last saw the deceased alive on _____ 19 ____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		31. SIGNATURE		32. DATE SIGNED	
33. PHYSICIAN'S NAME (Type)		34. ADDRESS		35. DATE	
36. BURIAL CREMATION, REMOVAL (Specify)		37. NAME OF CEMETERY or CREMATORY		38. LOCATION (City, town, or county) (State)	
39. DATE REC'D BY HEALTH DEPT.		40. NAME OF REGISTRAR		41. FUNERAL DIRECTOR	
42. AUG 10 1972		43. ADDRESS		44. BALTIMORE, MD	

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72 07614

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07614

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Wilmer J. Jackson

2. DATE

Known ☒Estimated ☐

Month

Day

Year

Hour

OF

DEATH

8

8

72

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF

(If not in hospital or institution, give street

HOSPITAL

ADDRESS OR LOCATION)

OR INSTITUTION

37 Mercy Hospital

3. DATE

Month

Day

Year

Hour

PRONOUNCED DEAD

8

8

72

12:00 p. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

908

6. SEX

male

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

9-18-37

10. AGE (In years

last birthday)

34

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

632 Cokesbury Avenue

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF

WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Andrew L. Jackson

14A. USUAL OCCUPATION (Give kind of work

done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Anna Mears

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL

SECURITY NO.

231-42-8304

18. INFORMANT

ADDRESS

Mrs. Anna Jackson 632 Cokesbury Ave. 21218

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Congestive heart failure

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiomyopathy

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

Thyrotoxicosis

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes - head only

22A. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIB-UTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about

home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location)

INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour)

OF INJURY

(APPROX.)

22E. INJURY OCCURRED

WHILE AT

WORK ☐

NOT WHILE

AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/9/72

24A. BURIAL CREMATION,

REMOVAL (Specify)

Burial

24B. DATE

8-11-1972

24C. NAME of CEMETERY or CREMATORY

Baltimore Cemetery

24D. LOCATION (City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT

AUG 10 1972

25B. NAME OF REGISTRAR

Sydney Whitton

25C. FUNERAL DIRECTOR

1735 Harford Ave, 21213
Marshall W. Jones, Jr.

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

MAIL ROOM

1964

1965

1966

1967

1968

1969

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07615

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07615

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAHUE HACKETT

2. DATE AND HOUR OF DEATH

JULY 31, 1972 4:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

8 MARYLAND GEN. HOSP.
827 LINDEN AVE.
BALTO., MD. 21201

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

501 DOPHINS

5. SEX

MALE

6. RACE

BLACK

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

APRIL 2, 1888 89

9. AGE (In years last birthday)

10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

PORTER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Moses Hackett

14. MOTHER'S MAIDEN NAME

Ariel JACKSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

218-10-4352

17. INFORMANT (DAUGHTER)

HELEN HACKETT

ADDRESS

501 DOPHINS ST. BALTO. MD.

18.

412.4 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE ASCVD, CHF, AF
DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 year (?)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Anemia, Etiology (?)

Bilateral Pulmonary Effusion, Pneumonia (L)

1 year (?)

few days

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 17, 1972 to July 31, 1972 that (I) (we) last saw the deceased alive on July 31, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Mallari

MD DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

July 31, 1972

23C. PHYSICIAN'S NAME (Type)

RT MALLARI

23D. ADDRESS

MARYLAND GEN. HOSP.
827 LINDEN AVE., BALTO., MD.

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 10 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07616 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 07616
STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MINNIE JEFFERSON

2. DATE AND HOUR OF DEATH

8-1-72 4:10PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTIONIF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATIONLUTHERAN Hospital of MD. Inc
730 Ashbarton ST

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE
MARYLAND

B. COUNTY

1503

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1810 RUXTON AVE.

5. SEX

6. RACE

F

N

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

6-18-1890

9. AGE (In years
last birthday)

82

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Robert Robinson

14. MOTHER'S MAIDEN NAME

Mentha Smith

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) If yes, give war or dates of service16. SOCIAL
SECURITY NO.

230-26-2032

17. INFORMANT

ms
Priscilla Rice Ruxton Ave

ADDRESS

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

CARDIORESPIRATORY ARREST

(B) - Questionable Aspiration
DUE TO, OR AS A CONSEQUENCE OF:

(C) - Post CVA

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH Involuntarily medical examiner21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(Month) (Day) (Year) (Hour)
APPROX.

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-10 1972 to 8-1-1972
that (I) (we) last saw the deceased alive on 8-1-1972 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Robert Robinson

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

AUG 11/72

23C. PHYSICIAN'S
NAME (Type)

Robert Robinson

23D. ADDRESS

LUTHERAN Hosp.

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

B 8/6/72

24C. NAME of CEMETERY or CREMATORY

Church Cn

24D. LOCATION

(City, town, or county)

(State)

Center Cross Va.

25A. DATE REC'D BY HEALTH DEPT.

AUG 10 1972

25B. NAME OF REGISTRAR

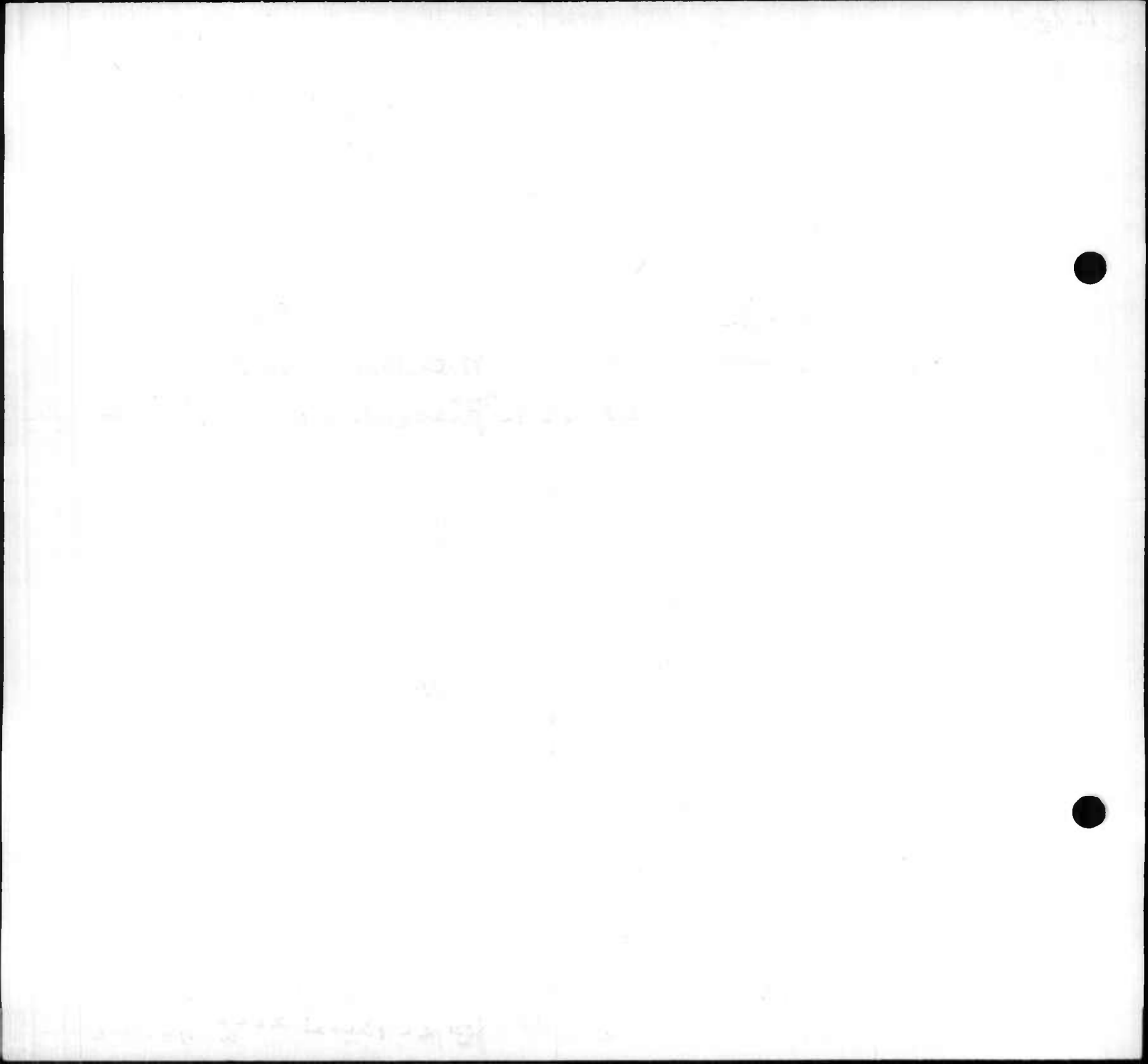
Ludwig Winkler

25C. FUNERAL DIRECTOR

Joseph C. Rizz

ADDRESS

2222 W north ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07617
72 07617				STATE OF MARYLAND-DHMH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Carol Ann James		
2. DATE AND HOUR OF DEATH August 9, 1972 3:30 A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3418 Orlando Avenue		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2735		5. SEX female 6. RACE caucasian 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8. DATE OF BIRTH March 5, 1962 9. AGE (In years last birthday) 10 yrs.		
E. STREET AND NUMBER 3418 Orlando Avenue		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10B. KIND OF BUSINESS OR INDUSTRY None		
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Lawrence J. James		14. MOTHER'S MAIDEN NAME Loretta Novak		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Lawrence J. James ADDRESS 3418 Orlando Ave 21234
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Cerebral palsy DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE Cerebral palsy (B) cataracts + myopia DUE TO, OR AS A CONSEQUENCE OF: (C) dehydration + Cholelithiasis + Malnutrition		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Since Birth		
MEDICAL CERTIFICATION				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II				
19A. DATE OF OPERATION 8/9/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 8/7/72 to 8/9/72 and that (I) (we) last saw the deceased alive on 8/7/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Dr. Donald W. Mintzer DEGREE				23B. DATE SIGNED August 10, 1972
23C. PHYSICIAN'S NAME (Type) Dr. Donald W. Mintzer M.D. DEGREE				23D. ADDRESS 3009 Evergreen Avenue Baltimore, Md.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 12, 72		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. FUNERAL DIRECTOR Dippel Bros Inc ADDRESS 7110 Belair Rd. 21206		
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1972		25B. NAME OF REGISTRAR L. J. Dippel		25C. FUNERAL DIRECTOR Dippel Bros Inc ADDRESS 7110 Belair Rd. 21206

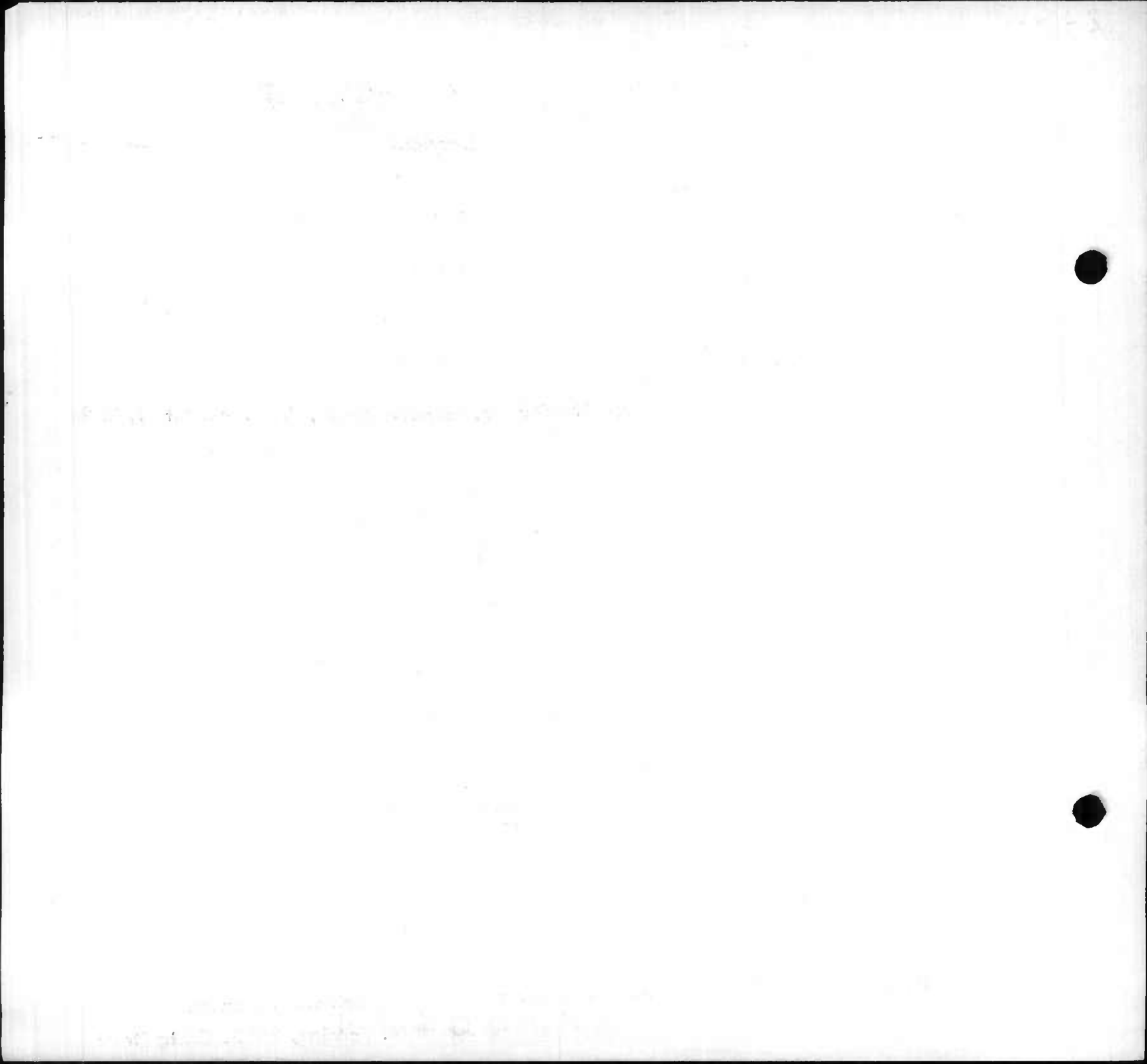
• 007-01

100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 07618		BALTIMORE CITY HEALTH DEPARTMENT		72 07618	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO. 72 07618	
AMATO, Mrs MARIE.		8/5/72 8:45/72		HEALTH & MENTAL HYGIENE	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. CITY OR TOWN	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY BALTO	
Church Home & Hospital.		C. CITY OR TOWN 44.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
35		E. STREET AND NUMBER 718 S. 49th. ST.			
5. SEX F	6. RACE White.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/11/19	9. AGE (in years last birthday) 53.	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife.				MD.	
13. FATHER'S NAME CONRAD SCHOCK.		14. MOTHER'S MAIDEN NAME ANNA KISTNER.		12. CITIZEN OF WHAT COUNTRY? AMER.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-09-6865		17. INFORMANT ADDRESS Mr. Salvatore Amato, 718 S. 49th Street, 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		HEPATIC COMA & GI bleeding		24 hrs.	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Several years.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		RECURRENT LUPOID.			
		(B) HEPATITIS.			
		DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/23/72 19 to 8/5/72 19 that (I) (we) last saw the deceased alive on 8/5/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Walker, A. Indagliatelli		8/5/72.		Walker, A. Indagliatelli	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/8/72		Oaklawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 10 1972		Joseph N. Zannino		Baltimore, Maryland	
				ADDRESS 263 S. Conly Street	



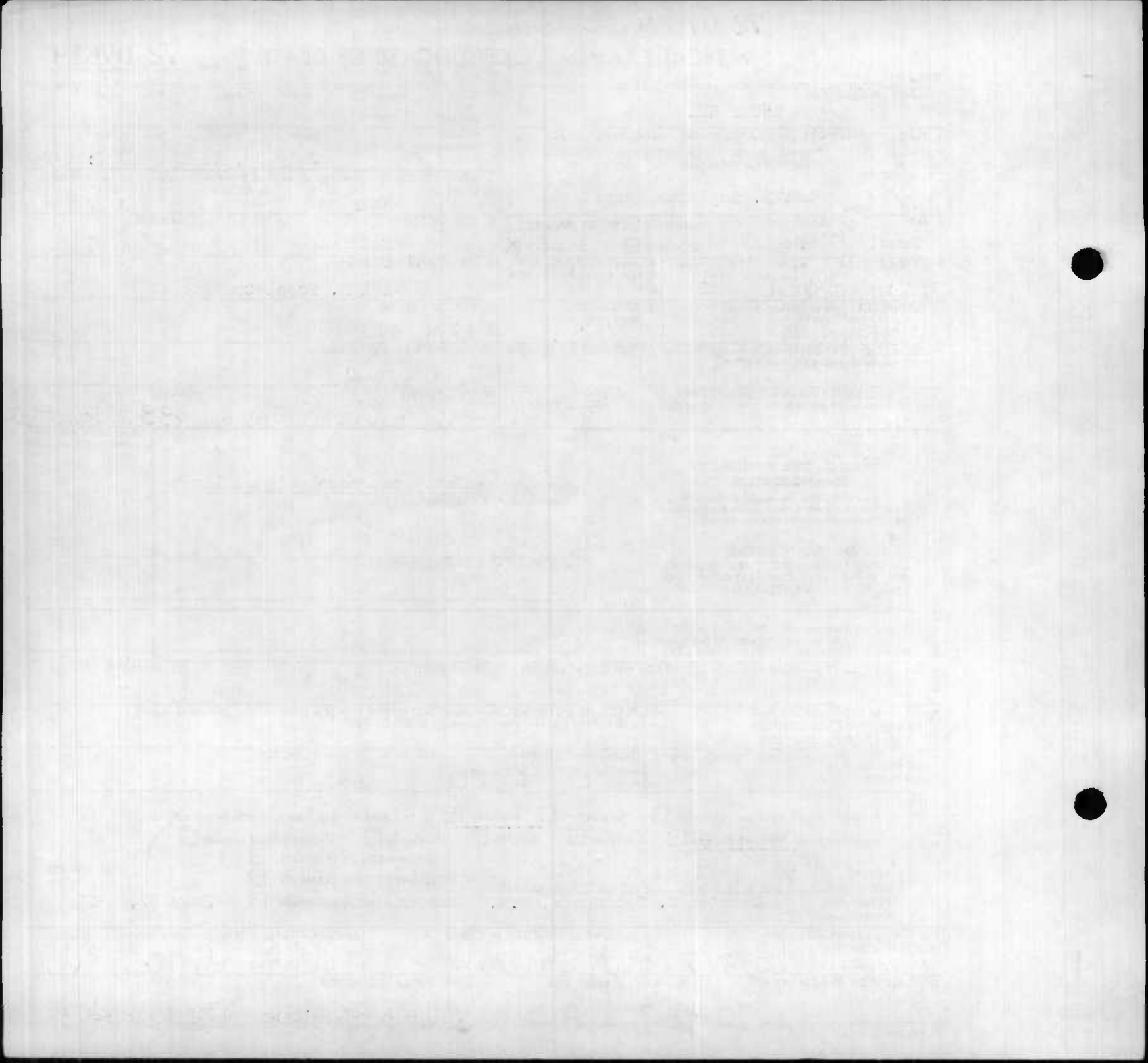
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND-DHMH

REG. NO. 72 07619

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BETTY LEE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 101 N. Poppleton Street		3. DATE PRONOUNCED DEAD Month Day Year Hour July 26, 1972 7:10 P.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH UNKNOWN		10. AGE (in years last birthday) 52	
11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME UNKNOWN		14. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Maryland B. COUNTY 1801	
15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. UNKNOWN		18. INFORMANT REV. Lewis CONAWAY	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		ADDRESS 833 W. Fayette St.	
20A. DATE OF OPERATION 8/7/72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type)		DATE SIGNED July 27, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/7/72	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) ANNE ARUNDEL Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR 972020	
25C. FUNERAL DIRECTOR William J. Spicer		ADDRESS 1639 N. Broadway	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07620

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT J. PENNINGTON

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

MARYLAND GENERAL HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

August 6, 1972

1:10 A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

1504

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

March 27, 1950

10. AGE (In years
lost birthday)

22

11. Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

2330 Reistertown Road

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Louis Pennington

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Kitchen Helper

14B. KIND OF BUSINESS OR INDUSTRY

Hospital

15. MOTHER'S MAIDEN NAME

Anna Williams

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

219-62-1075

18. INFORMANT

ADDRESS

Louis Pennington 2330 Reistertown r

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

Gunshot wound of chest

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Sidewalk

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

747 Blk. Druid Park Lake Drive

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

8-6-72

A.M.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot during altercation

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/6/72

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

8/9/72

24C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cem

24D. LOCATION (City, town, or county)

Balto. Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 10 1972

25B. NAME OF REGISTRAR

Sidney W. Boston

25C. FUNERAL DIRECTOR

Williams Funeral Home

ADDRESS

319 N. Sepulchre St

JOHN J. FERRARO

JOHN J. FERRARO

JOHN J. FERRARO

JOHN J. FERRARO

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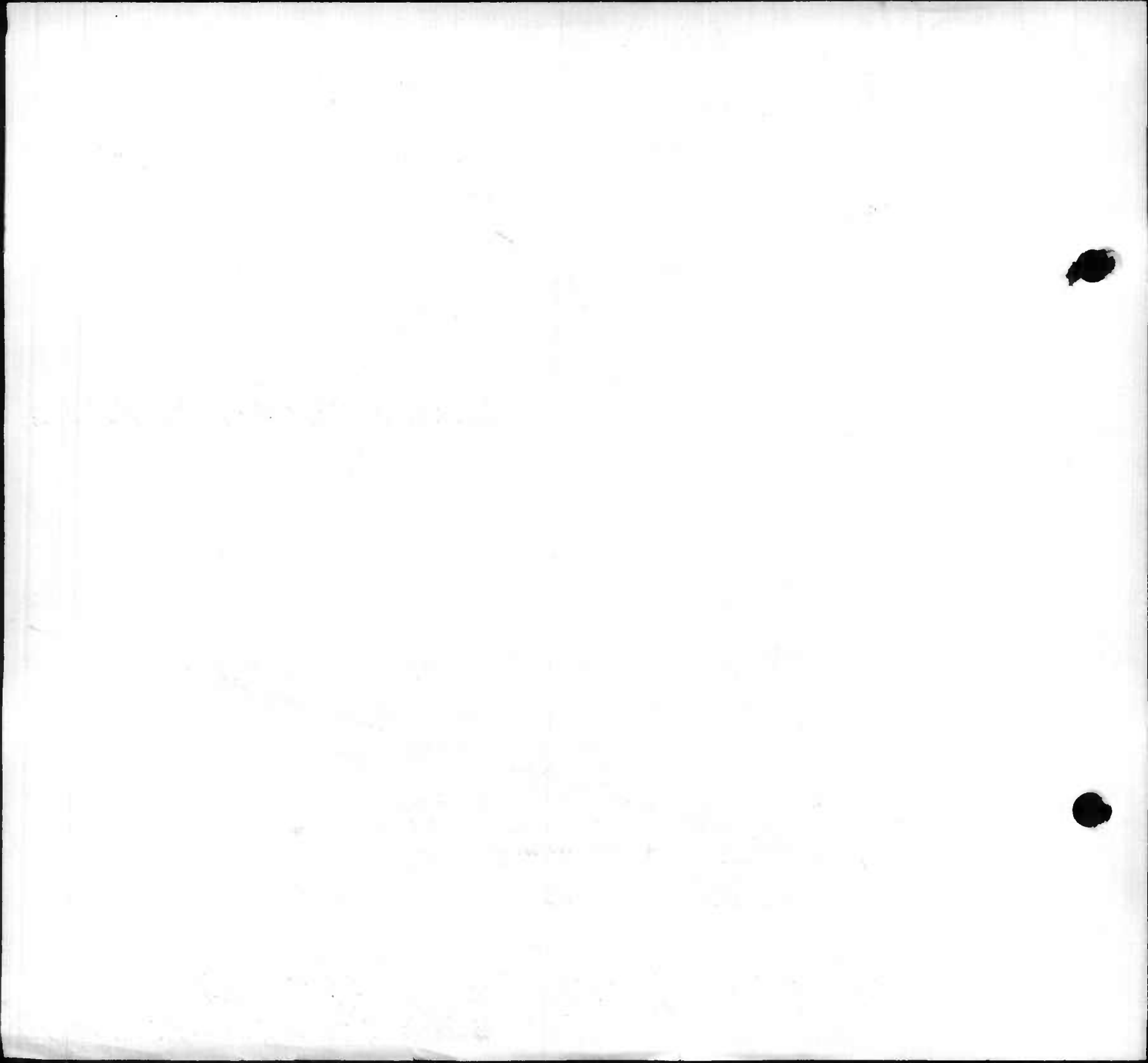
JOHN J. FERRARO

JOHN J. FERRARO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07621	
72 07621				STATE OF MARYLAND-DHMH	
BIRTH NO. 70-11799				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) RODERICK ROBINSON		2. DATE AND HOUR OF DEATH 6 August 1972 4:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital 38		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1511 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3637 Duffield Ave			
5. SEX M	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-14-70	9. AGE (in years last birthday) 2	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balti, md.	
13. FATHER'S NAME Dallas Robinson		14. MOTHER'S MAIDEN NAME Veronica Powell		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Veronica Powell 3637 Duffield Ave	
18. I 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hydrocephalus ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hydrocephalus (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that at (this hospital) attended the deceased from 1 Aug 1972 to 6 Aug 1972 that he (we) last saw the deceased alive on 6 Aug 1972 and that in the (our) opinion death occurred on the date and hour and from the causes stated above. (We) (We) (did) not view the body after death.					
23A. SIGNATURE Walker Robinson MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6 Aug 72	
23C. PHYSICIAN'S NAME (Type) WALKER ROBINSON MD		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/72		24C. NAME OF CEMETERY OR CREMATORY W. C. C. Cemetery	
24D. LOCATION Balti. Md.		24E. CITY, TOWN, or county		24F. STATE (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1972		25B. NAME OF REGISTRAR Frederick W. W. W.		25C. FUNERAL DIRECTOR William W. W. W.	
25D. ADDRESS 3199 Schroeder St					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07622

BIRTH NO.

STATE OF MARYLAND-DEATH

1. NAME OF DECEASED (Type or Print) ERNEST QUARRELS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 3 1972 6:45a M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Wash., D.C.	
9. DATE OF BIRTH Sept 2 1948		10. AGE (In years last birthday) 23	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZENSHIP U.S.A.	
13. FATHER'S NAME Ernest E Quarrels Sr.		14. MOTHER'S MAIDEN NAME Abrena Morgan	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war and dates of service) NO		18. SOCIAL SECURITY NO. 9	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hr.	
20A. DATE OF OPERATION 8-3-72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) highway	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Int. 95 and Rt. 16		22D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) OF INJURY (APPROX.) 8-3-72 m a. m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot self.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Marvin S. Platt EXAMINER'S NAME (Type) Marvin S. Platt, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-3-72	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/9/72	
24C. NAME OF CEMETERY or CREMATORY Lincoln Cemetery		24D. LOCATION (City, town, or county) (State) SUITLAND MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1972		25B. NAME OF REGISTRAR Sidney Anderson	
25C. FUNERAL DIRECTOR W.E. Jarvis		ADDRESS 1432 700 St. N.W. D.C.	

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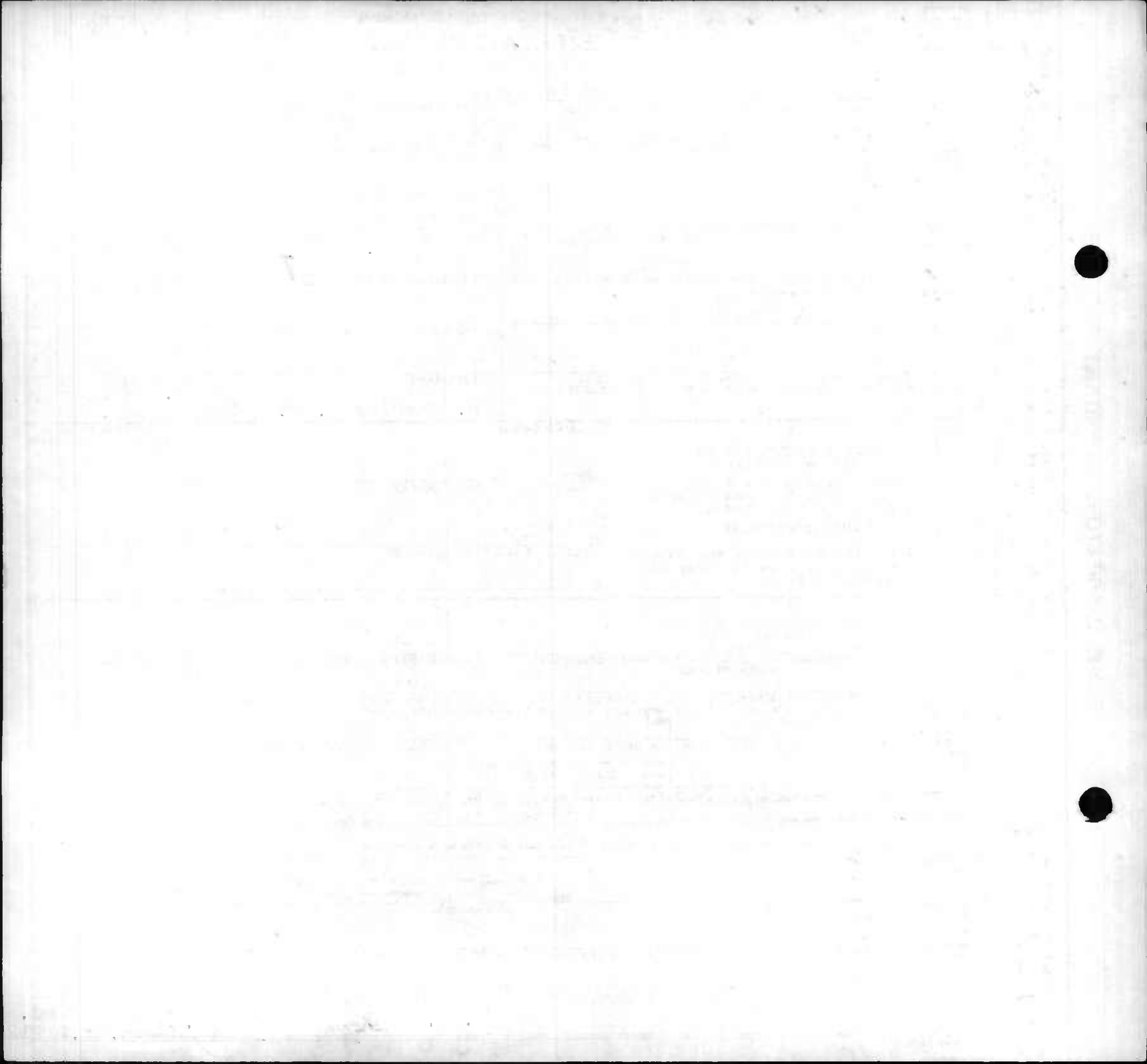
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

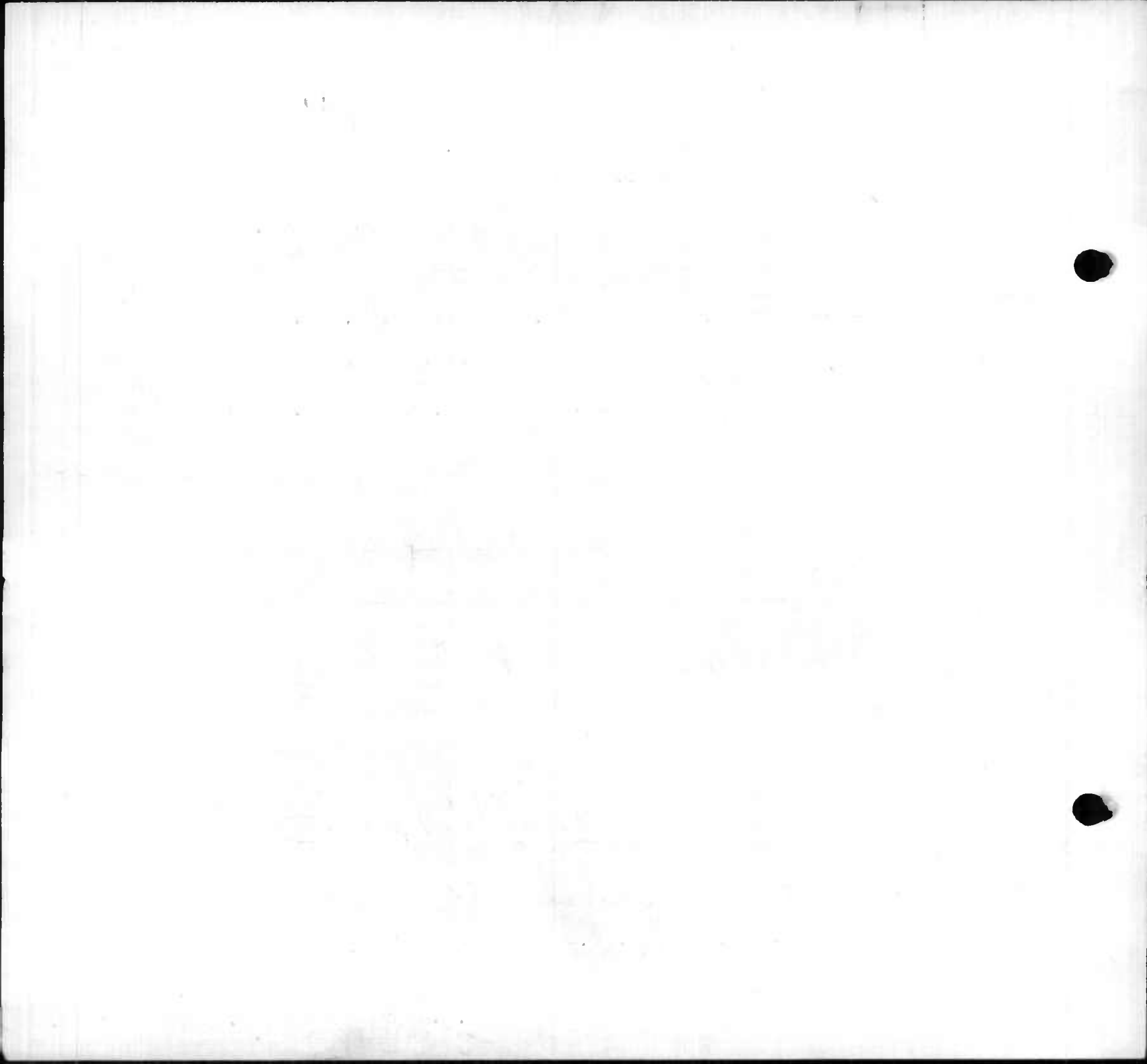
BALTIMORE CITY HEALTH DEPARTMENT				72 07623		REG. NO. 72 07623	
CERTIFICATE OF DEATH							
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MATHIESEN, ANNA M.		2. DATE AND HOUR OF DEATH 8/9/72 11:20 AM		STATE OF MARYLAND-DHMH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY U.S.A.			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 10/10/93		9. AGE (In years last birthday) 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXPERIMENTAL PSYCHOLOGIST		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) IOWA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME NEILS MATHIESEN				14. MOTHER'S MAIDEN NAME ERMANANE MARGARET WILSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Charles R. Goldsborough, Jr.			
18. 412.31		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		ARREST 1 YR.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC HEART DISEASE				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). PERICARDITIS							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 7/28/72 19 to 8/9/72 19 that (1) (we) last saw the deceased alive on 8/9/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE GEBREYE W. RUFAEL				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/9/72	
23C. PHYSICIAN'S NAME (Type) GEBREYE W. RUFAEL				23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 8-10-72		24C. NAME OF CEMETERY or CREMATORY Green Mount Crematory		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.			
				4905 York Rd. Balto. Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07624		REG. NO. 72 07624	
BIRTH NO.				STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Kenneth W. Grimm				8/9/72 9:30 P.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
38 University of Maryland				Md. 275-8			
E. STREET AND NUMBER				D. INSIDE CITY LIMITS?			
1523 Sherwood Ave. 21239				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7-9-12	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
60		Packing-Co-ordinator Lever Bros.		Warwood, W. Va.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Walter E. Grimm				Zelma Smith			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes WW II				233-01-5680		Mrs. Kenneth W. Grimm	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF: Massive pulmonary embolus 24hrs.			
ANTECEDENT CAUSES				(B)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) showing the UNDERLYING CONDITION last				Rt. deep vein thrombosis 3wks.			
(C)							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/9 1972 to 8/9 1972 that (I) (we) last saw the deceased alive on 8/9 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Louis E. Grenzer				8/9/72		Louis E. Grenzer, M. D.	
23D. ADDRESS				24A. BURIAL CREMATION, REMOVAL (Specify)			
Staff-University Hospital				Burial			
24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.	
8-12-72		Cedar Hill Cemetery		Anne Arundel Co., Maryland		25B. NAME OF REGISTRAR	
				H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212		25C. FUNERAL DIRECTOR ADDRESS	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07625

BIRTH NO. 70-15402

STATE OF MARYLAND-DHMH

1. NAME OF DECEASED (Type or Print) LISA ROBINSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour August 5, 1972 12:30 P.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2102	
9. DATE OF BIRTH Aug-5-1920		10. AGE (In years last birthday) 2yr. 7	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME Richard D. Robinson		15. MOTHER'S MAIDEN NAME Mildred I. Robinson	
18. INFORMANT Mildred I. Robinson		ADDRESS 606 Washington Blvd.	

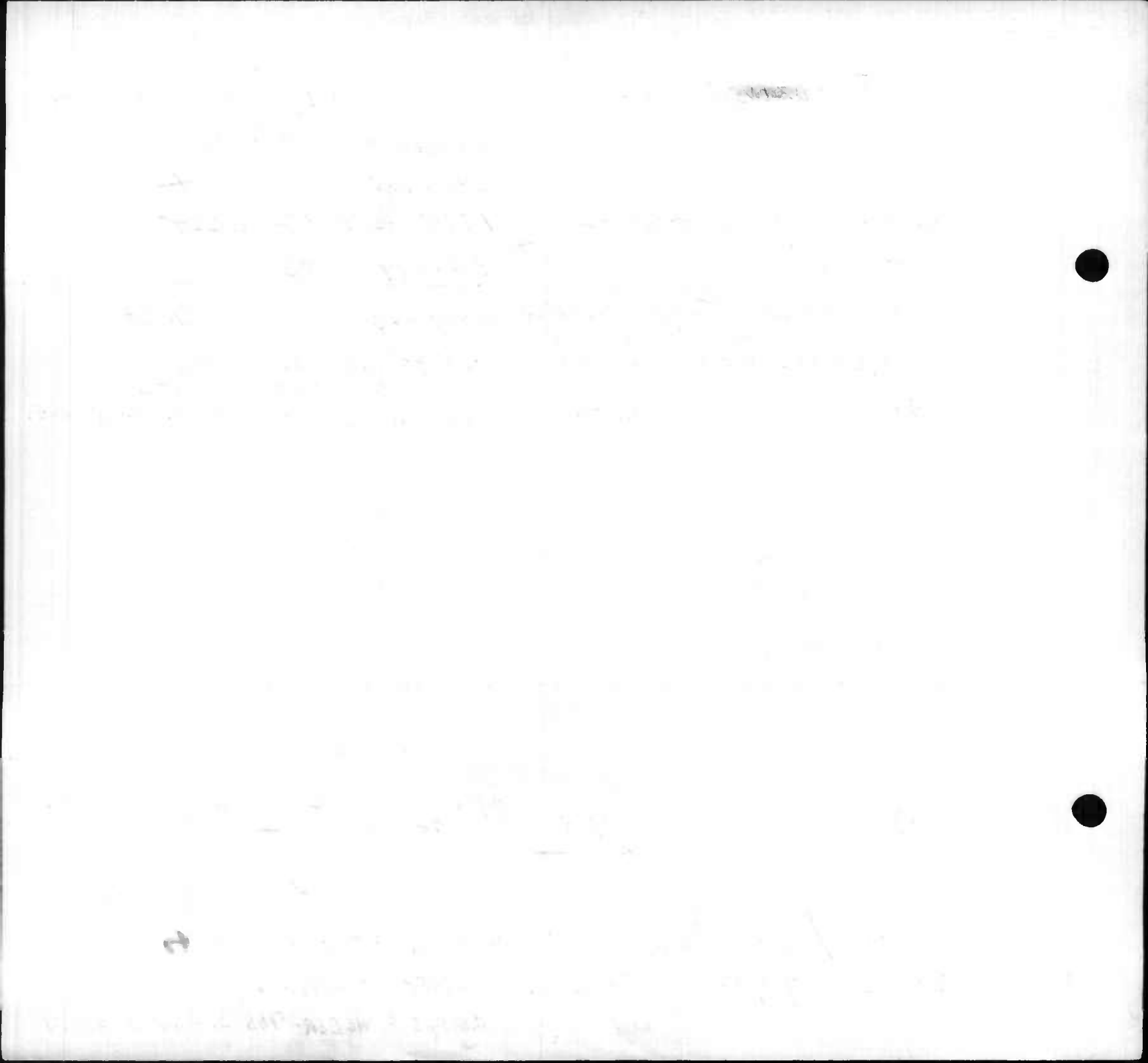
19. E8551.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Tofranil intoxication DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1227 S. Carey Street 21-02	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 8-4-72 About 6:00 P.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Child took pills from Foster-mother's purse	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/6/72					
ACTUAL SIGNATURE Marvin S. Platt EXAMINER'S NAME (Type) Marvin S. Platt, M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug-11-1972		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1972		25B. NAME OF REGISTRAR Sidney H. Workman		25C. FUNERAL DIRECTOR Charles F. Hughes	
				ADDRESS 1532 Hollins St	

8-31-1972 - Completion of cause of death on a pending medical examiner death certificate
Marvin S. Platt, M.D. HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07626 BALTIMORE CITY HEALTH DEPARTMENT		72 07626	
CERTIFICATE OF DEATH		STATE OF MARYLAND-DEM	
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) JAGODZINSKI-ANNA		2. DATE AND HOUR OF DEATH 6:55 A.M. 8/9/1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY #21231 203	
FULL NAME OF HOSPITAL OR INSTITUTION 91 MONTEBELLO STATE HOSPITAL		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-22-99 9. AGE (In years last birthday) 73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF-EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY TAVERN OPERATOR	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MICHAEL JAGODZINSKI		14. MOTHER'S MAIDEN NAME CATHERINE SOLTYSIAK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-36-2773	
17. INFORMANT MRS. FRANCES R. NIGHT		ADDRESS PATIENT'S CHART-5222 GWYNDALE AVE.	
18. 244X1 CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Massive pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF: Hypothyroidism. Hx of thrombophlebitis.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CVA with hemiplegia, atrial fibrillation DUE TO, OR AS A CONSEQUENCE OF: (C) Urinary tract infection.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/6 19 72 to 8/9 19 72 that (we) last saw the deceased alive on 8/8 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Y. Chang		23B. DATE SIGNED 8/9/72	
23C. PHYSICIAN'S NAME (Type) Young Oak Chang		23D. ADDRESS Montebello State Hosp. Baltimore, Md.	
24A. BURIAL CREMATION REMOVAL (Specify) BURIAL		24B. DATE 8/12/72	
24C. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1972		25B. NAME OF REGISTRAR George A. Weber	
25C. FUNERAL DIRECTOR GEORGE A. WEBER-765 S. ANN ST.		ADDRESS #21231	



FUNERAL DIRECTOR: IMPORTANT

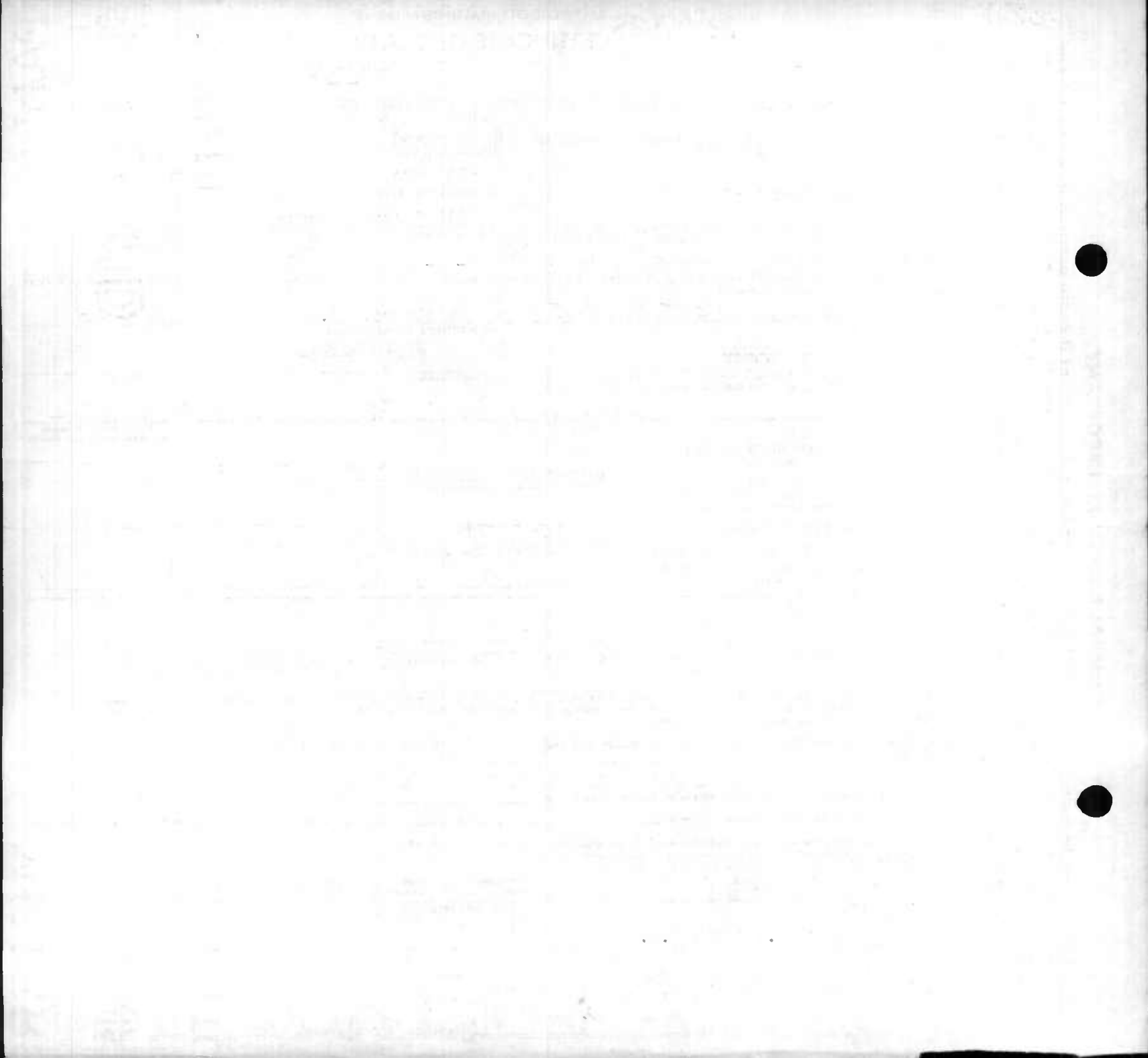
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 07627 CERTIFICATE OF DEATH				REG. NO. 72 07627 STATE OF MARYLAND-DMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CORA JOHNSON		2. DATE AND HOUR OF DEATH 8 AUG 72 1 33⁰ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSP. OF BALTO. INC.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN REISTERSTOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 409 CENTRAL AVE.		
5. SEX F	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/14/84	9. AGE (In years last birthday) 88	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME WILLIAM CHIVIS			14. MOTHER'S MAIDEN NAME LULA WALKER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 228-64-9940		17. INFORMANT NORMAN F. JOHNSON, 630 Brandywine St., SE WASHINGTON, D.C.
18. 153.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF: (B) Carcinoma Cecum & Liver DUE TO, OR AS A CONSEQUENCE OF: Metastases (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Known 3 wks Known 3 weeks.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 7-20-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ca Cecum/Liver-Metast.		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indefinitely medical examined) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) [Month] [Day] [Year] [Hour]		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 7-18 19 72 to 8-8 19 72 that (X) (we) last saw the deceased alive on 8-8 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Michael Schultz</i>				23B. DATE SIGNED 8 AUG. 72	
23C. PHYSICIAN'S NAME (Type) SCHULTZ, MICHAEL M.D.				23D. ADDRESS SINAI HOSP. OF BALTO- INC.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/11/72		24C. NAME OF CEMETERY or CREMATORY MARYLAND NAT. PARK	
24D. LOCATION (City, town, or county) (State) LAUREL, MD.		25A. DATE REC'D BY HEALTH DEPT. AUG 11 1972			
25B. NAME OF REGISTRAR <i>Audrey H. Weston</i>		25C. FUNERAL DIRECTOR NELSON E. GREENE 814 FRANKLIN ST. ALEXANDRIA, VIRGINIA			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07628 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 7 REG. NO. 72 07628

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Conrad Gummer		2. DATE AND HOUR OF DEATH 8-8-72 1:10p M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy hospital				4. USUAL RESIDENCE I Where deceased lived, II institution: residence before admission) A. STATE Maryland B. COUNTY BALTO 5300 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1114 Chesaco Avenue	
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-24-10	9. AGE (In years last birthday) 62	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker			10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Peter Gummer		
14. MOTHER'S MAIDEN NAME Viola Hartlove			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 084-07-0577			17. INFORMANT Marie Gummer ADDRESS 1114 Chesaco Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 250.91 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD (C) Diabetes mellitus		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chronic Lung Disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 and that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John E. Seible M.D.				23B. DATE SIGNED 8/8/72	
23C. PHYSICIAN'S NAME (Type) John E. Seible M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/72		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Balto Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 11 1972			
25B. NAME OF REGISTRAR Sydney [Signature]		25C. FUNERAL DIRECTOR Cash Funeral Home 1211 Chesaco Ave			



F-5401

72 07629

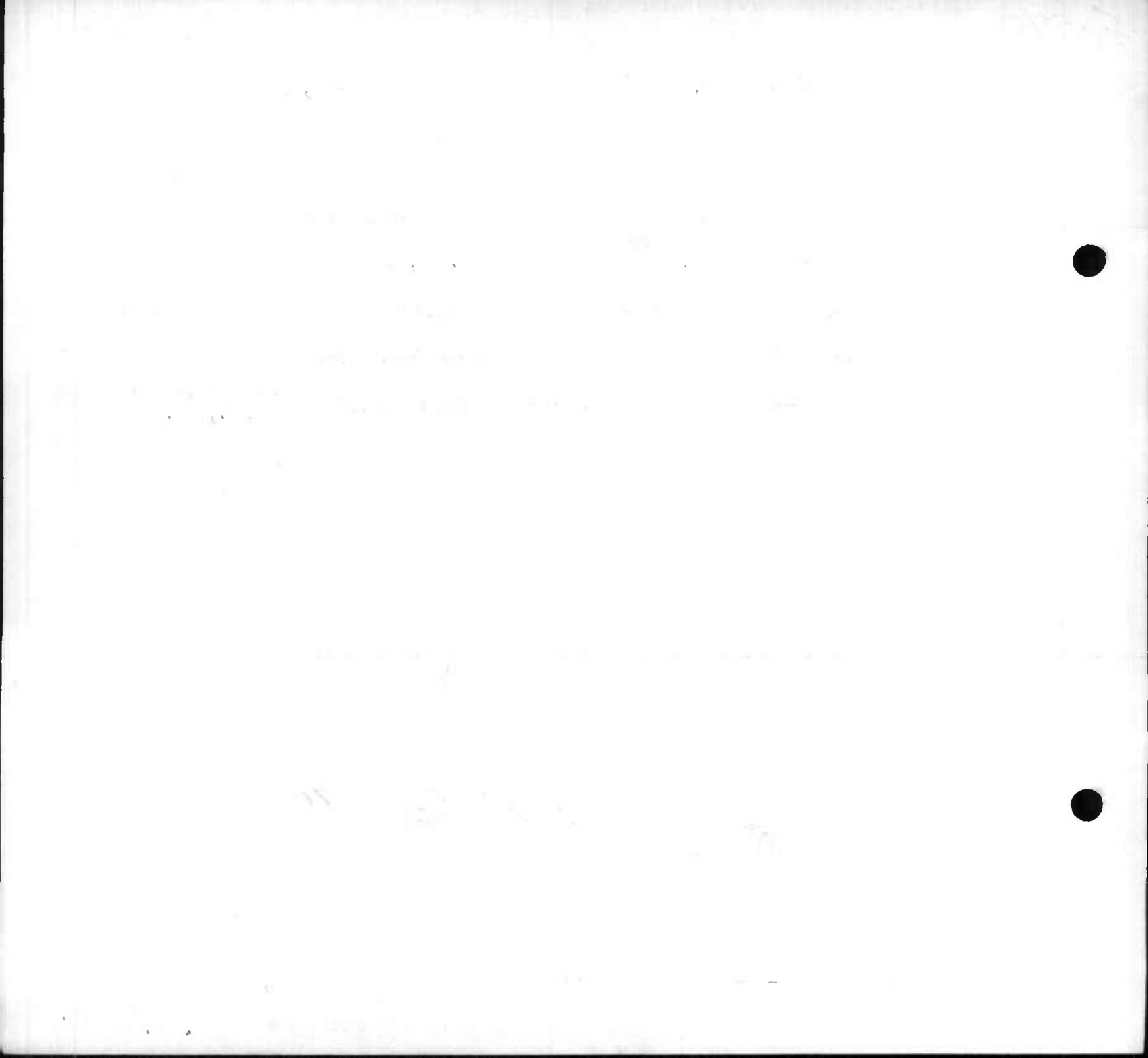
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 07629

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Virginia M. Finley</i>		2. DATE AND HOUR OF DEATH <i>August 9, 1972</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2403</i>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>1202 Riverside Avenue</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>1202 Riverside Avenue</i>					
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 11, 1906</i>	9. AGE (in years last birthday) <i>65</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Our Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Walter Norwood</i>			
14. MOTHER'S MAIDEN NAME <i>Mary Agnes Myers</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>216 42 9624</i>		17. INFORMANT <i>Mildred Grunder</i>			
ADDRESS <i>1202 Riverside Avenue Balto., Md. 21230</i>					
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Recurrent myocardial infarction</i> (B) <i>Atherosclerotic heart dis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1-7</i> 19 <i>71</i> to <i>8-9</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>7-7</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED <i>8-9-72</i>		23C. PHYSICIAN'S NAME (Type) <i>Gen. Koveti</i>	
23D. ADDRESS <i>100 N Broadway</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-12-72</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Cross Cemetery</i>	
24D. LOCATION <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 11 1972</i>		25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <i>McElly Funeral Home</i>	
ADDRESS <i>130 East Front Ave. Balto., Md. 21230</i>					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



R-2001

72 07630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 07630

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ROBERT M. RAUSCH

2. DATE AND HOUR OF DEATH

August 7 1972

12⁴⁵ P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

TALBOT

7000

C. CITY OR TOWN

Newcombe

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

5. SEX

Male

6. RACE

Cauc

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

5-29-00

9. AGE (In years
last birthday)

72

11. Under 1 Yr.
Months: Days:If Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CRAFTSMAN

10B. KIND OF BUSINESS OR INDUSTRY

METAL WORKING

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

ROBERT RAUSCH

14. MOTHER'S MAIDEN NAME

CAROLINE MITTENDORF

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

016-09-4287

17. INFORMANT

ADDRESS

Mrs. Edith W. Rausch, Newcomb, Md.

18. 441.21 + 204.1

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

Hypoxia

DUE TO, OR AS A CONSEQUENCE OF:

Post Repair LEAKING Abdominal

18 hrs

(B)

Aortic Aneurysm

DUE TO, OR AS A CONSEQUENCE OF:

36 hrs

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Chronic Lymphatic Leukemia

5 yrs

19A. DATE OF OPERATION

August 6 1972

19B. CONDITION FOR WHICH OPERATION

Leaking
Aortic Aneurysm

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

No

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from August 5 1972 to August 7 1972
that (I) (we) last saw the deceased alive on August 7 1972 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

William B. Long M.D.

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

August 7 1972

23C. PHYSICIAN'S
NAME (Type)

WILLIAM B. LONG, M.D.

DEGREE

23D. ADDRESS

University Hospital, Baltimore, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Aug 10, 1972

24C. NAME of CEMETERY or CREMATORY

Woodlawn Mem. Park

24D. LOCATION

Easton

(City, town, or county)

Talbot

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 11 1972

25B. NAME OF REGISTRAR

Anthony J. Horton

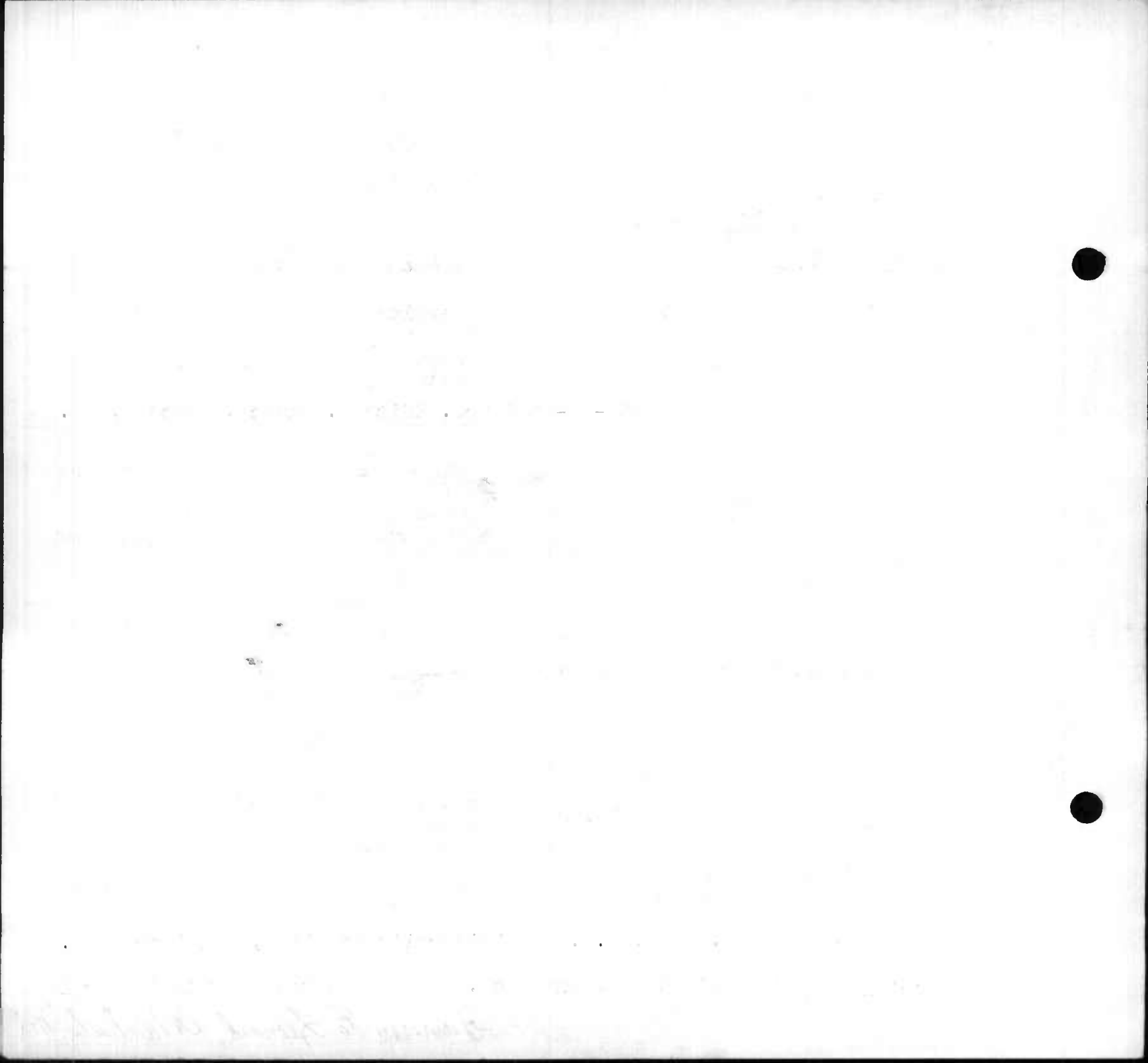
25C. FUNERAL DIRECTOR

James E. Leonard, St. Michaels, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 07631

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Juliette Cohen

2. DATE AND HOUR OF DEATH

August 7, 1972

3:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

91 LEVINDALE

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

E. STREET AND NUMBER

841 LAKE DRIVE

D. INSIDE CITY LIMITS?

YES ☐NO ☐

5. SEX

Female

6. RACE

WHITE
Human7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

5-5-1893

9. AGE (In years
last birthday)

79

If Under 1 Yr.
MonthsIf Under 24 Hrs.
Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

RUSSIA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

212-01-5855A

17. INFORMANT

ADDRESS

DR. ELIAS COHEN, 78 THISTLE AVE., TONAWANDA, N.Y.

18. 4369 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE PULMONARY EMBOLISM
DUE TO, OR AS A CONSEQUENCE OF:APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

4 Hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) CEREBRO VASCULAR ACCIDENT
DUE TO, OR AS A CONSEQUENCE OF:

YEARS

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

ARTERIOSCLEROTIC HEART DISEASE

YEARS

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At
Work ☐Not White
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~MD~~ (this hospital) attended the deceased from February 3 19 64 to August 7 19 72
that ~~XX~~ (we) last saw the deceased alive on August 7 19 72 and that in ~~(my)~~ (our) opinion death occurred on the date
and hour and from the causes stated above. ~~XX~~ (We) (did) ~~not~~ view the body after death.

23A. SIGNATURE

Soon Chul Hong, M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

August 7, 1972

23C. PHYSICIAN'S
NAME (Type)

SOON CHUL HONG, M.D.

23D. ADDRESS

LEVINDALE

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

8/9/72

24C. NAME OF CEMETERY or CREMATORY

HEBREW FRIENDSHIP

24D. LOCATION

(City, town, or county)

BALTIMORE, MARYLAND

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 11 1972

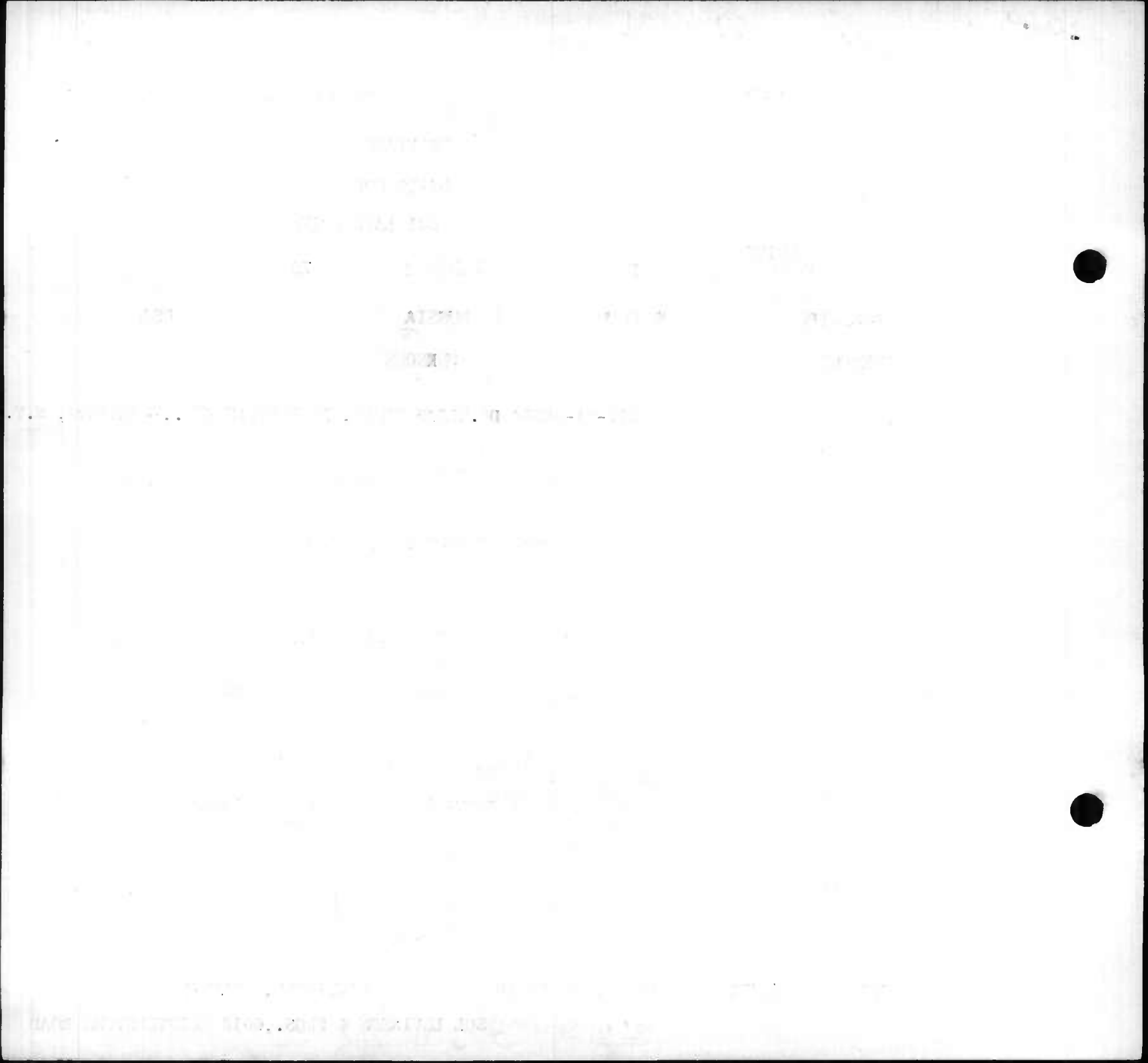
25B. NAME OF REGISTRAR

Sidney Levinson

25C. FUNERAL DIRECTOR

SOLO LEVINSON & BROS., 6010 REISTERSTOWN ROAD

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07632

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07632

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LENA STOLER

2. DATE AND HOUR OF DEATH

AUGUST 7, 1972

3:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)HAMILTON NURSING HOME
6040 HARFORD ROAD4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

4401 LOCH RAVEN BLVD.

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

APRIL 1, 1889

9. AGE (In years
lost birthday)

83

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

RUSSIA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

218-32-4217

17. INFORMANT

ADDRESS

MR. MEYER STOLER, 3708 BEECH AVE. #21211

18. 440.91

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:Cardiac failure
generalized arterio-sclerosis
and acute agitation

(B) DUE TO, OR AS A CONSEQUENCE OF:

Hypertension

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/8 1972 to 8/7 1972,
that (I) (we) last saw the deceased alive on 8/5 1972 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

DEGREE

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

8/8/72

23C. PHYSICIAN'S
NAME (Type)

I. W. Fromm

23D. ADDRESS

8014 Harford Road

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/8/72

24C. NAME of CEMETERY or CREMATORY

ANSHE NEISEN

24D. LOCATION

(City, town, or county)

ROSEDALE, MARYLAND

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 11 1972

25B. NAME OF REGISTRAR

Arlene B. Weston

25C. FUNERAL DIRECTOR

SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

ADDRESS

UNITED STATES

DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

AND HOUSE OF REPRESENTATIVES

APRIL 1, 1900

WASHINGTON

DEPARTMENT OF JUSTICE

AT WASHINGTON

DEPARTMENT OF JUSTICE

DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

Handwritten notes:
The following is a list of the names of the persons who have been appointed to the various positions in the Department of Justice, and who have been sworn in as such.

Handwritten signature:
J. Edgar Hoover

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07633	
72 07633 CERTIFICATE OF DEATH				STATE OF MARYLAND-DHMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MOLLIE EDELSON		AUGUST 7, 1972 8 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRIEDLERS GUEST HOUSE 2449 SHIRLEY AVENUE			A. STATE		B. COUNTY
			MARYLAND		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			2449 SHIRLEY AVENUE #21215		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	NOV. 20, 1889	82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		AT HOME		RUSSIA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
MOSES GOLDBERG			LENA FINE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				DR. FRED SCHOLNICK, 8248 STREAMWOOD DR. #21208	
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
			Acute passive congestion of lungs (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: arteriosclerotic heart disease (B) DUE TO, OR AS A CONSEQUENCE OF: Parturition Disease		2 days 5 years 5 years
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Jan 14 1967 to Aug 7 1972 , that (I) (we) last saw the deceased alive on Aug 7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Manuel Levin MD				23B. DATE SIGNED 8/7/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
MANUEL LEVIN				6101 PARK HEIGHTS AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		8/8/72		OHR KNESSETH ISRAEL ANSHE SFARD, ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 11 1972		Sidney H. Winston		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 07634</u>
72 07634				STATE OF MARYLAND-DHMH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) KURT JULIUS OPPENHEIMER		
2. DATE AND HOUR OF DEATH AUGUST 8, 1972		7 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5500 WINNER AVENUE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2719		
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH JUNE 20, 1909		9. AGE (In years last birthday) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JACOB OPPENHEIMER		14. MOTHER'S MAIDEN NAME ROSE ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. HERMINE OPPENHEIMER, 5500 WINNER AVE. #15
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.31 Sudden Cardiac Arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary Artery Disease Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yr 7 yrs 7 yrs		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>1972</u> that (I) (we) last saw the deceased alive on <u>7/23</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Edward S. Kallins MD</i> DEGREE				23B. DATE SIGNED <u>8/8/72</u>
23C. PHYSICIAN'S NAME (Type) EDWARD S. KALLINS		23D. ADDRESS 6000 PARK HEIGHTS AVENUE		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/9/72		24C. NAME OF CEMETERY or CREMATORY CHEVRA AHAVAS CHESSED
24D. LOCATION (City, town, or county) (State) RANDALLSTOWN, MARYLAND		25A. DATE REC'D BY HEALTH DEPT.		
25B. NAME OF REGISTRAR 972000		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		

RECEIVED
JAN 10 1964

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

FILE: [Illegible]

NOTED: [Illegible]

APPROVED: [Illegible]

RECEIVED
JAN 10 1964

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

FILE: [Illegible]

NOTED: [Illegible]

APPROVED: [Illegible]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07635	
72-7635				STATE OF MARYLAND-DHMH	
BIRTH NO.		72-7635 <td colspan="2">CERTIFICATE OF DEATH</td>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Mr. George Donoghue		8/6/72 12:38 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
Keswick Home of Baltimore City		Maryland			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M		W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Resident of Agent		N.Y. Life Ins. Co.		9-28-1882	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		9. AGE (In years last birthday) 89	
Baltimore, Md.		USA		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Jeremiah Donoghue		Katherine Lavine		Yes W.W. 1 1916	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
219-14-1978		Records-The Keswick Home		Baltimore Maryland	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Encephalomalacia,		at least 10 years	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		General & cerebral arteriosclerosis			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (if this hospital) attended the deceased from 7/13/63 19 to 8/6/72 19 that (we) last saw the deceased alive on 8/6/72 19 and that (my) death occurred on the date and hour and from the causes stated above. (I) (did) (view) the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
W.B. Daniels, Jr. M.D.		8/6/72		W.B. Daniels, Jr. M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		9 Aug 72		Druid Ridge Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 11 1972		Audrey Whitton		Burgee Funeral Home, Baltimore, Maryland	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)		24F. LOCATION (City, town, or county) (State)	
Pikesville, Balto Co. Maryland		3631 Falls Rd. Balto., Md. 21211			

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

72-7636
REG. NO. [REDACTED] 8

STATE OF MARYLAND-DHMH

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) **WITTNER, ANNA LOUISE**

2. DATE AND HOUR OF DEATH **AUGUST 6, 1972** **5:45P** M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **MD.** B. COUNTY _____

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
ST AGNES HOSPITAL
WILKENS & CATON AVES.
BALTIMORE, MARYLAND 21229

C. CITY OR TOWN **BALTIMORE** D. INSIDE CITY LIMITS? YES ☒ NO ☐

E. STREET AND NUMBER **1011 W. 37TH. STREET**

5. SEX **FEMALE** 6. RACE **WHITE** 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH **01 05 93** 9. AGE (In years last birthday) **79** If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **HOUSEWIFE** 10B. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (State or foreign country) **MARYLAND** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **THADEUS SHEPPARD** 14. MOTHER'S MAIDEN NAME **KITURAH SHIPLEY**

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) **NO** 16. SOCIAL SECURITY NO. **230 14 3983** 17. INFORMANT **ST AGNES RECORDS WILKENS & CATON AVES.** ADDRESS _____

18. **183.0 I** CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
19A. DATE OF OPERATION _____ 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) **NO** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____ 21E. INJURY OCCURRED While At ☐ Work Not While At ☐ Work 21F. HOW DID INJURY OCCUR? _____

22. I certify that (I) (this hospital) attended the deceased from **August 1** 19 **72** to **August 6** 19 **72**, that (I) (we) lost saw the deceased alive on **August 6** 19 **72** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE **Chumsak Paksapong** M.D. 23B. DATE SIGNED **August 6, 1972**

23C. PHYSICIAN'S NAME (Type) **CHUMSAK PAKSAPONG** M.D. 23D. ADDRESS **ST AGNES HOSPITAL WILKENS & CATON AVES.**

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **9 Aug 72** 24C. NAME OF CEMETERY or CREMATORY **ONE Cranford Cemetery** 24D. LOCATION (City, town, or county) (State) **Occoquan, Prince William Co, Va**

25A. DATE REC'D BY HEALTH DEPT. **AUG 11 1972** 25B. NAME OF REGISTRAR **Andrew J. [Signature]** 25C. FUNERAL DIRECTOR **Burgee Funeral Home, Baltimore, Maryland** ADDRESS _____

2:00

AUGUST 8, 1932

ST. JAMES HOSPITAL

NY

BALTIMORE

ST. JAMES HOSPITAL

1211 N. 37TH STREET

BALTIMORE, MARYLAND 2120

NY

01 02 23

REAR END WHITE

1.0.4.

MARYLAND

HOUSEWIFE

KIRKMAN SHIRLEY

THOMAS THE PRIMO

ST. JAMES RECORDS WICKENS & CATTAN

NO

NO

ST. JAMES HOSPITAL WICKENS & CATTAN

PAGE 1

R-500

72 07637 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07637
STATE OF MARYLAND-DEATH

BIRTH NO.		1. NAME OF DECEASED (Type or Print) M. ROWAN DOROTHY ROWAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 5457 Park Heights Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 6 1972 7:15p M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2717	
6. SEX female	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Jun 21, 1907	10. AGE (In years last birthday) 65	11. BIRTHPLACE (State or foreign country) Maryland		E. STREET AND NUMBER 5457 Park Heights Ave.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Leonard J. Brown		15. MOTHER'S MAIDEN NAME Francis Ford	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		14B. KIND OF BUSINESS OR INDUSTRY - - -		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 218 22 4322		18. INFORMANT Mrs. June Jeffery		ADDRESS 32 Wooded Way APT 2	
19. 571.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Fatty metamorphosis of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) PARTIAL	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE William P. Mulloy, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-7-72					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9 aug 72		24C. NAME of CEMETERY or CREMATORY Lorraine Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 11 1972		25B. NAME OF REGISTRAR J. E. Lowell	
25C. FUNERAL DIRECTOR J. E. Lowell		25D. ADDRESS 6500 York Road			

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[illegible text follows]

100-100000

William S. [illegible]

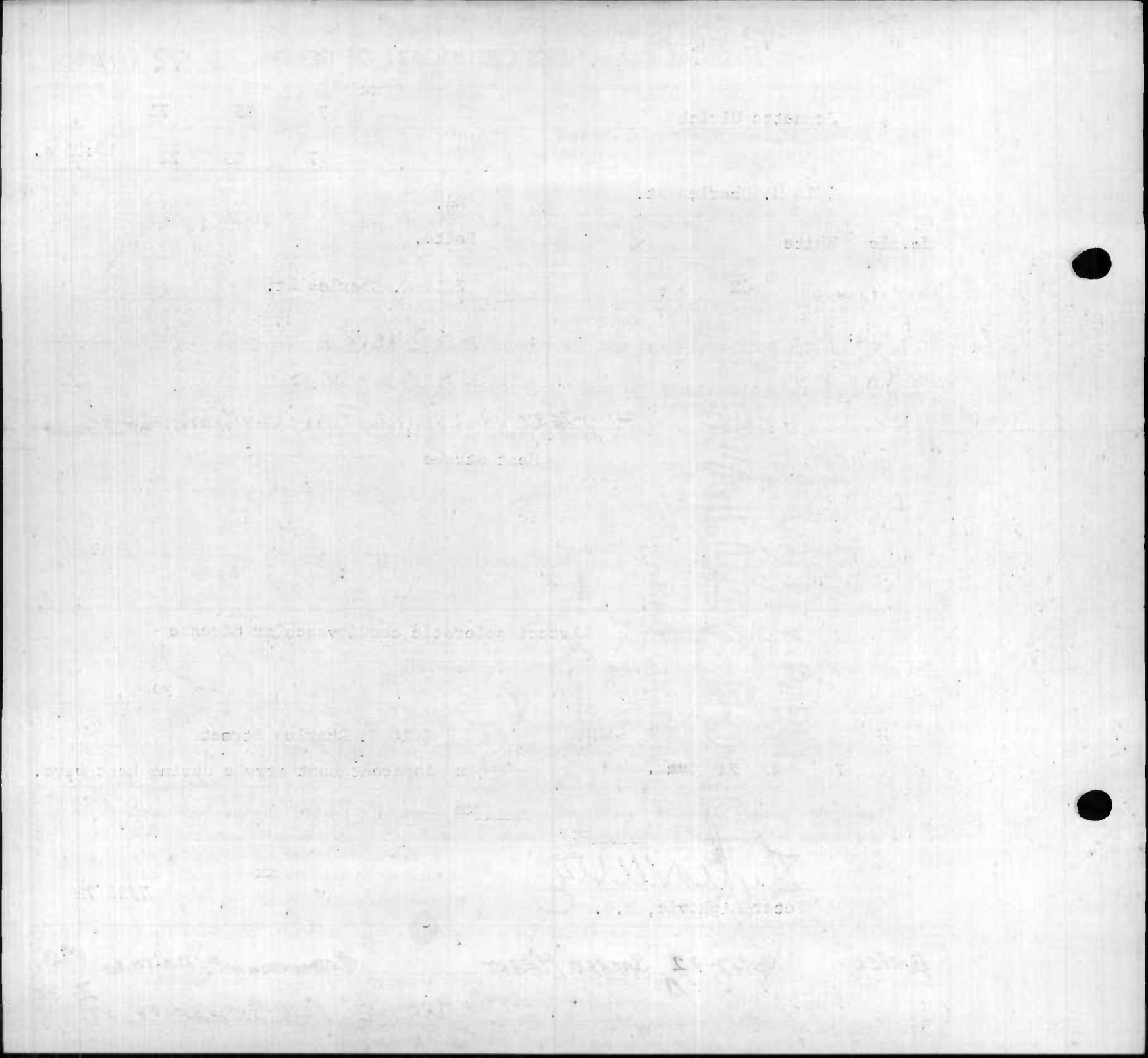
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07638

BIRTH NO.

STATE OF MARYLAND-DEMH

1. NAME OF DECEASED (Type or Print) Jeanette Ulrich		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 25 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2010 N. Charles St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 25 72 10:05 a. M.	
6. SEX female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH UNKNOWN		10. AGE (In years last birthday) 62	
11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1206	
15. MOTHER'S MAIDEN NAME UNKNOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE		17. SOCIAL SECURITY NO. 27-01-7637	
18. INFORMANT JAMES LIBERTINI		ADDRESS 320 CATHEDRAL ST.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E900X		CAUSE OF DEATH Heat Stroke	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21. DATE OF OPERATION 2		22. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME	
25. TIME OF INJURY (APPROX.) Month Day Year Hour 7 25 72		26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
27. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2010 N. Charles Street		28. HOW DID INJURY OCCUR? Apparent heat stroke during heat wave.	
29. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 7/25/72			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE AUG 7-72	
24C. NAME OF CEMETERY or CREMATORY SACRED HEART		24D. LOCATION (City, town, or county) (State) GERMANTOWN RD BALTO. CO MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1972		25B. NAME OF REGISTRAR Sidney W. Houston	
25C. FUNERAL DIRECTOR KRAUSE		ADDRESS 1216 S. CHARLES ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-2601

72 07639

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

72 07639

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARGUERITE MCGUIRE

2. DATE AND HOUR OF DEATH

7/27/72 6 55 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL
414

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE B. COUNTY

22 Walden Av. Pikesville, Md. 21208

C. CITY OR TOWN

Pikesville

D. INSIDE CITY LIMITS?

YES ☐ NO ☒

E. STREET AND NUMBER

5300

5. SEX

Female

6. RACE

White

7. MARRIED

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

8-23-98

9. AGE (In years last birthday)

73

10. Under 1 Yr.

Months Days

11. Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

NEW YORK - U.S.A.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Donahue

14. MOTHER'S MAIDEN NAME

MARY MAHONY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

None

16. SOCIAL SECURITY NO.

213-57-9692

17. INFORMANT

Miss Catherine McGuire, 10656 Maryland Rd., Bethesda, Md.

ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Myocardial Infarction

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

1 Month 1 Day 1 Year 1 Hour

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/21/72 1972 to 7/27 1972 that (I) (we) last saw the deceased alive on 7/27/72 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M. S. H. C.

MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

7/27/72

23C. PHYSICIAN'S NAME (Type)

MAWYA SAO CAIR

MD

23D. ADDRESS

Union Memorial Hosp. Baltimore Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/31/72

24C. NAME OF CEMETERY OR CREMATORY

St. David's Cemetery

24D. LOCATION

Pikesville Md.

(City, town or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 11 1972

25B. NAME OF REGISTRAR

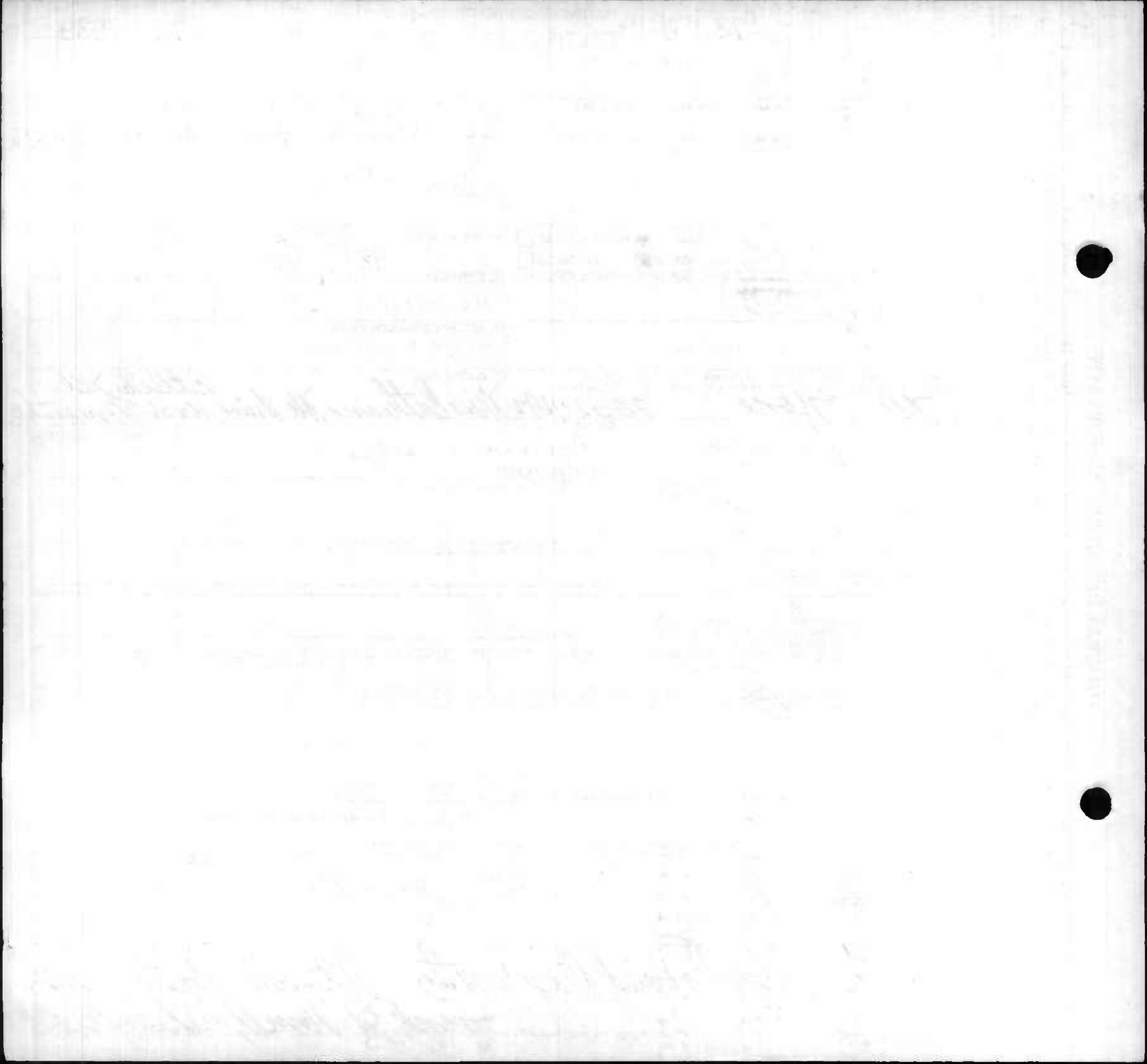
Frederick H. Hoston

25C. FUNERAL DIRECTOR

Frank J. Havel

ADDRESS

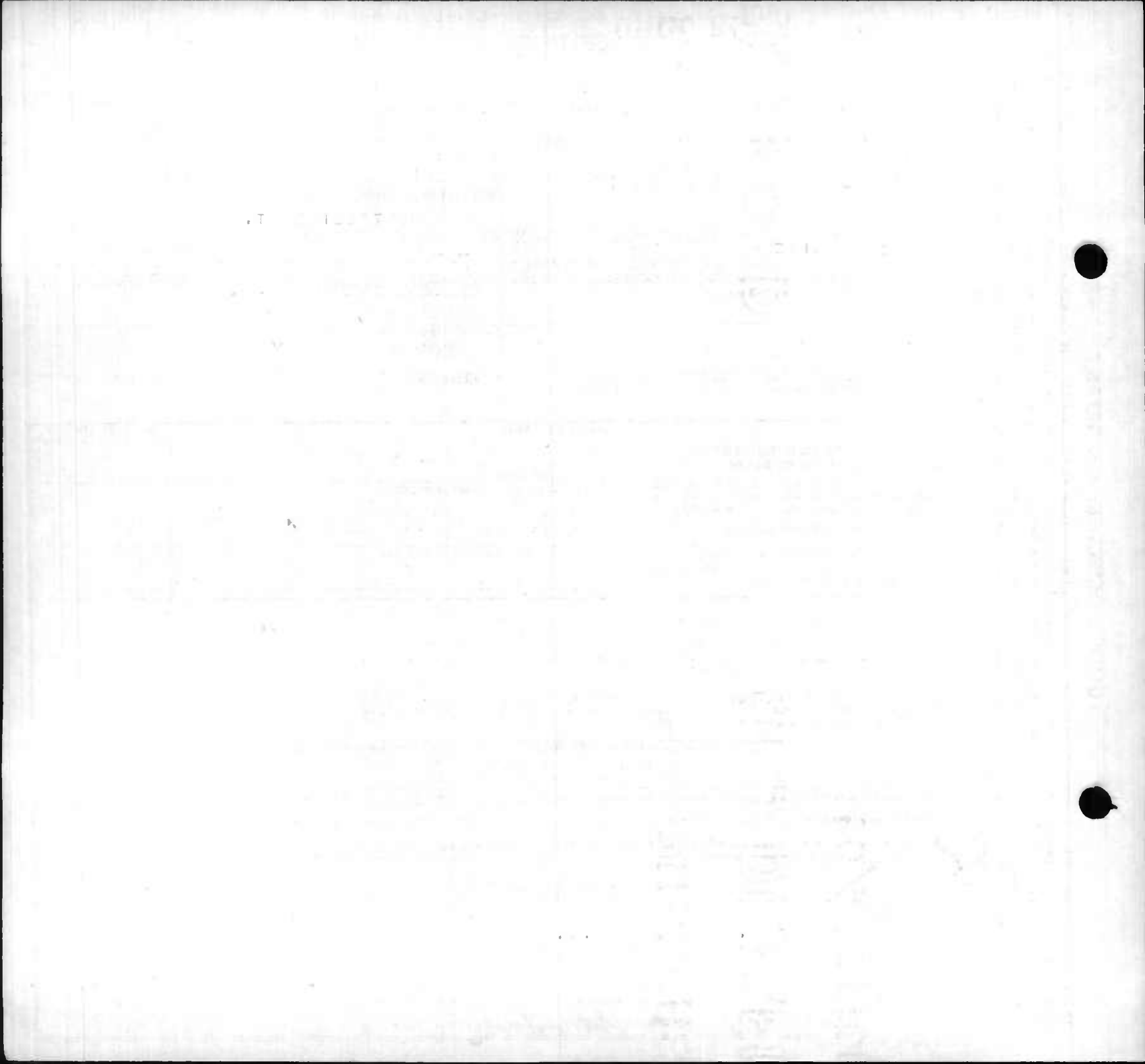
Pikesville Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07640	
72 07640				STATE OF MARYLAND-DMH	
BIRTH NO. 72-11294		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH August 9, 1972 4:26 A.M.	
1. NAME OF DECEASED (Type or Print) Baby Boy Broseker		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) MARYLAND			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
33		E. STREET AND NUMBER 609 MONTEPELIER ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-72	9. AGE (In years last birthday) 904	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Union Memorial Hosp. Baltimore, Maryland	
13. FATHER'S NAME CHARLES BROSEKER		14. MOTHER'S MAIDEN NAME DONNA MAHAFFEY		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 746.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cardiac Arrhythmia		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Ischemia			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Acyanotic Congenital Heart Disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Hyperbilirubinemia					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 8 1972 to August 9 1972 that (I) (we) last saw the deceased alive on August 9 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Roger A. Brumback M.D.				23B. DATE SIGNED 8/9/72	
23C. PHYSICIAN'S NAME (Type) ROGER A. BRUMBACK M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 8/9/72		24C. NAME OF CEMETERY or CREMATORY Johns Hopkins Hospital	
24D. LOCATION 601 N. Broadway Balto., Md.		24E. CITY, TOWN, or COUNTY		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

11-600

72 07641

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 07641
STATE OF MARYLAND-DHMH

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MOORE Guilford		2. DATE AND HOUR OF DEATH August 8, 72 8:30 am.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland - Baltimore B. COUNTY 703			
FULL NAME OF HOSPITAL OR INSTITUTION Good Samaritan Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 904 N. PATTERSON AVE.					
5. SEX M	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-10-89	9. AGE (In years last birthday) 83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) NORTH CAROLINE	
12. CITIZEN OF WHAT COUNTRY? American citizenship					
13. FATHER'S NAME Tom MOORE		14. MOTHER'S MAIDEN NAME Anna MOORE -			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 242-60908		17. INFORMANT Thelma Graham 1030 M^cDonough	
18. 5-90,01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osseous, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic renal failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yes	
		(B) chronic pyelonephritis -		yes	
		(C) obstructive uropathy -		yes.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Luis CARRILLO		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED August 8, 72	
23C. PHYSICIAN'S NAME (Type) Luis M. CARRILLO		23D. ADDRESS 5125-B WESTERN Blvd. BALT. MD 21209			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-14-72		24C. NAME of CEMETERY or CREMATORY Mt. Auburn CEM.	
24D. LOCATION (City, town, or county) (State) Westport, Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1972		25B. NAME OF REGISTRAR Ludwig W. Houston		25C. FUNERAL DIRECTOR Ellen J. FORD	
		ADDRESS 1129 N. Carolina			

A

58-57-99 djr

72 07642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 07642

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Patricia Gladden

2. DATE AND HOUR OF DEATH

8/7/72 15:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

C. CITY OR TOWN Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

906 McDonough Street 20205

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

9/9/31/1954

9. AGE (In years last birthday)

18

10. If Under 1 Yr. Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Steward

14. MOTHER'S MAIDEN NAME

Maggie Thacker

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no (unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

-

17. INFORMANT

4940 Eastern Avenue
BCH: RECORDS Baltimore, Maryland 21224

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardio-Respiratory Arrest - 5/11

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Hodgkin Disease 2 years

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

-

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

-

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

-

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

-

21C. WHERE DID INJURY OCCUR?

-

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At Work ☐Not White At Work ☐

21F. HOW DID INJURY OCCUR?

-

22. I certify that (I) (this hospital) attended the deceased from July 11, 1972 to 8/7 1972 that (I) (we) last saw the deceased alive on 8/7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

MICHELE CODINI MD

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

8/7/72

23C. PHYSICIAN'S NAME (Type)

MICHELE CODINI

23D. ADDRESS

4940 Eastern Avenue
BCH Baltimore, Maryland 21224

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/11/72

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem.

24D. LOCATION

Westport Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 11 1972

25B. NAME OF REGISTRAR

Andrew Johnston

25C. FUNERAL DIRECTOR

Michael E. Elchen

ADDRESS

1129 Madison

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Hedgwin Disease

ACH

WICKET COIN

James C. Wain

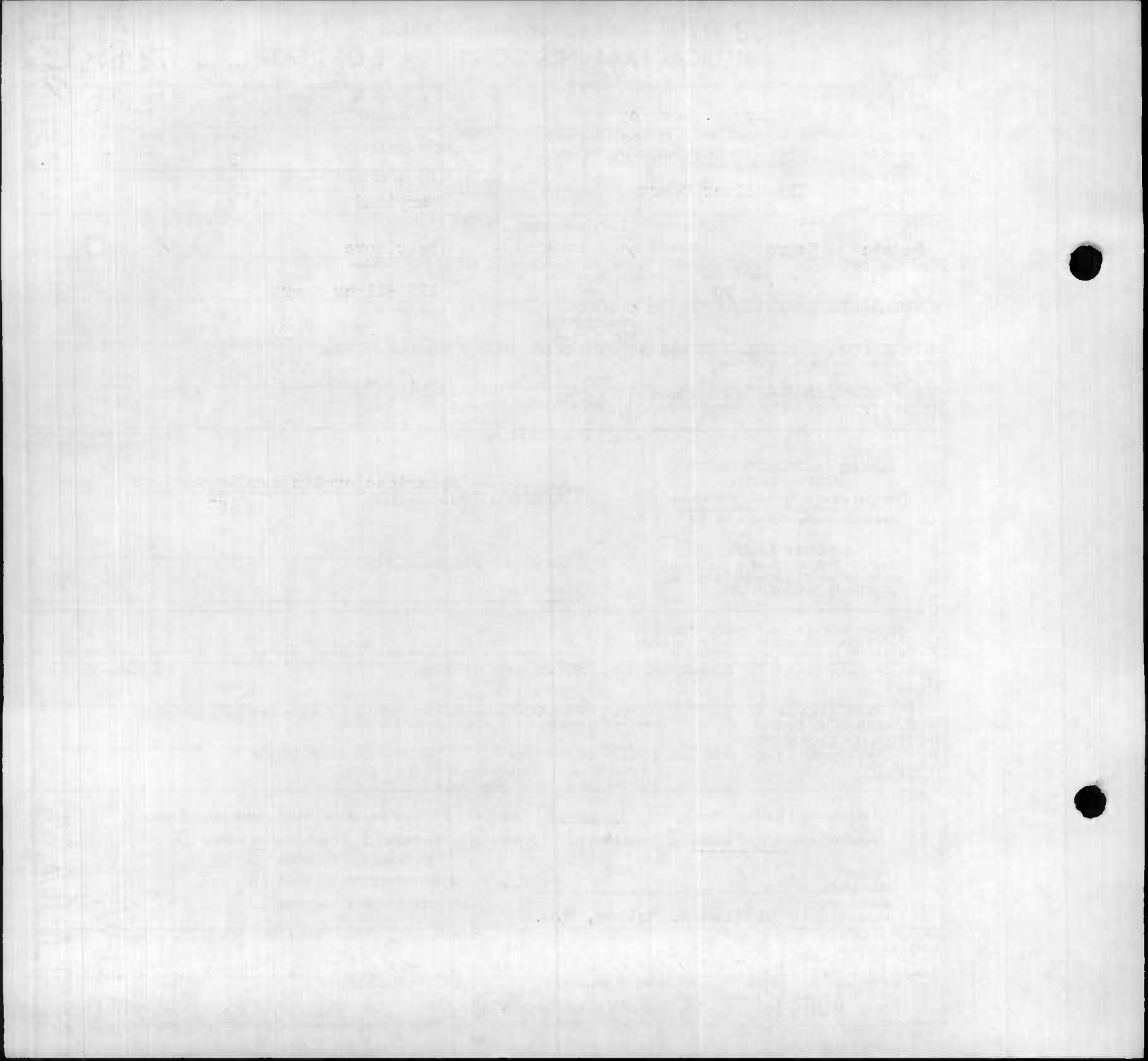
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07643

BIRTH NO.

STATE OF MARYLAND-DEMD

1. NAME OF DECEASED (Type or Print) Mary M. Wormley		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 8 3 72 7:25 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 239 Silver Court		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 3 72 7:25 P.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 4-9-82		10. AGE (In years last birthday) 90	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF U.S.	
13. FATHER'S NAME Daniel Berry		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 665	
15. MOTHER'S MAIDEN NAME Julian ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Eva Hughes 239 Silver Ct.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE William P. Mulloy, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-4-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-8-72	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Westport, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1972		25B. NAME OF REGISTRAR Sidney Johnston	
25C. FUNERAL DIRECTOR Elliot G. Gurnea		ADDRESS 11297 Laurel	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07644

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ernest Jackson

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month 8

Day 3

Year 72

Hour 11:22 P.

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

3. DATE
PRONOUNCED DEAD

Month 8

Day 3

Year 72

Hour 11:22 P.

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

B. COUNTY

808

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

12-18-36

10. AGE (In years
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1214 N. Bond Street

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF

WHAT COUNTRY?

13. FATHER'S NAME

Jesse Jackson

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Cleo Jackson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Ronald Jackson - 1516 E. Biddle St.

19.

E965X

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Gunshot wound of chest
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)
Street22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?

1500 blk. E. Biddle Street

808

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) 8 3 72 10:50 P. m.22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

shot during argument

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

William P. Mulloy, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
8-4-7224A. BURIAL CREMATION,
REMOVED (Specify)

24B. DATE

8-7-72

24C. NAME OF CEMETERY or CREMATORY

Arbatus Mem. Park

24D. LOCATION (City, town, or county)

Arbatus, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 11 1972

25B. NAME OF REGISTRAR

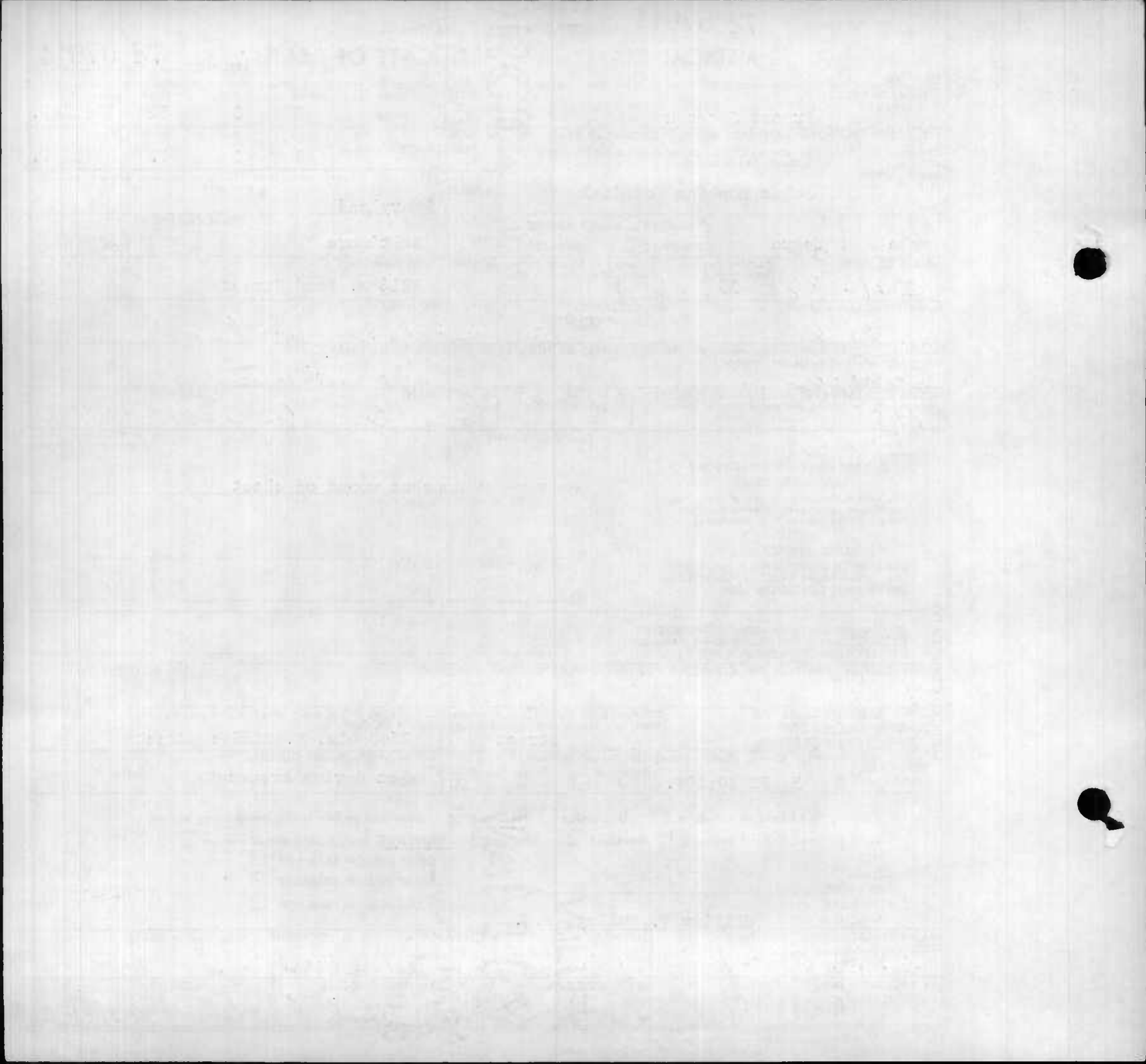
Audrey Whitton

25C. FUNERAL DIRECTOR

William E. Chicken

ADDRESS

1129 N. Calvert



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-4301

72 07645

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 07645
STATE OF MARYLAND-DRMH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

HEWLETT, Mrs. MARIE

2. DATE AND HOUR OF DEATH

9th AUGUST. 11 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Church Home & Hospital
Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MD.

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

11 S. CAROLINE STREET. 21231

5. SEX

F

6. RACE

C

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

3-3-02

9. AGE (In years last birthday)

70

If Under 1 Yr. Months

Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

HOUSE WIFE

11. BIRTHPLACE (State or foreign country)

VA

12. CITIZEN OF WHAT COUNTRY?

AMER.

13. FATHER'S NAME

JOSH BLYTHERS

14. MOTHER'S MAIDEN NAME

MARIE MARVEL.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service

No

16. SOCIAL SECURITY NO.

220 05 4204

17. INFORMANT

ULYSSES HEWLETT.

ADDRESS

2622 FEDERAL ST.

18. 450X1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

CARDIO PULMONARY ARREST

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

20 min.

(B) PUL. EMBOLISM?
DUE TO, OR AS A CONSEQUENCE OF:

2 hrs?
30 min?

(C) CARDI AC. FAILURE?

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/6/1972 to 8/9/1972
that (I) (we) last saw the deceased alive on 8/9/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

L. PADMARAJU M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

8/9/72

23C. PHYSICIAN'S NAME (Type)

L. PADMARAJU M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial 8-14-72

BALto National Cem. BALto.

BALto.

Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

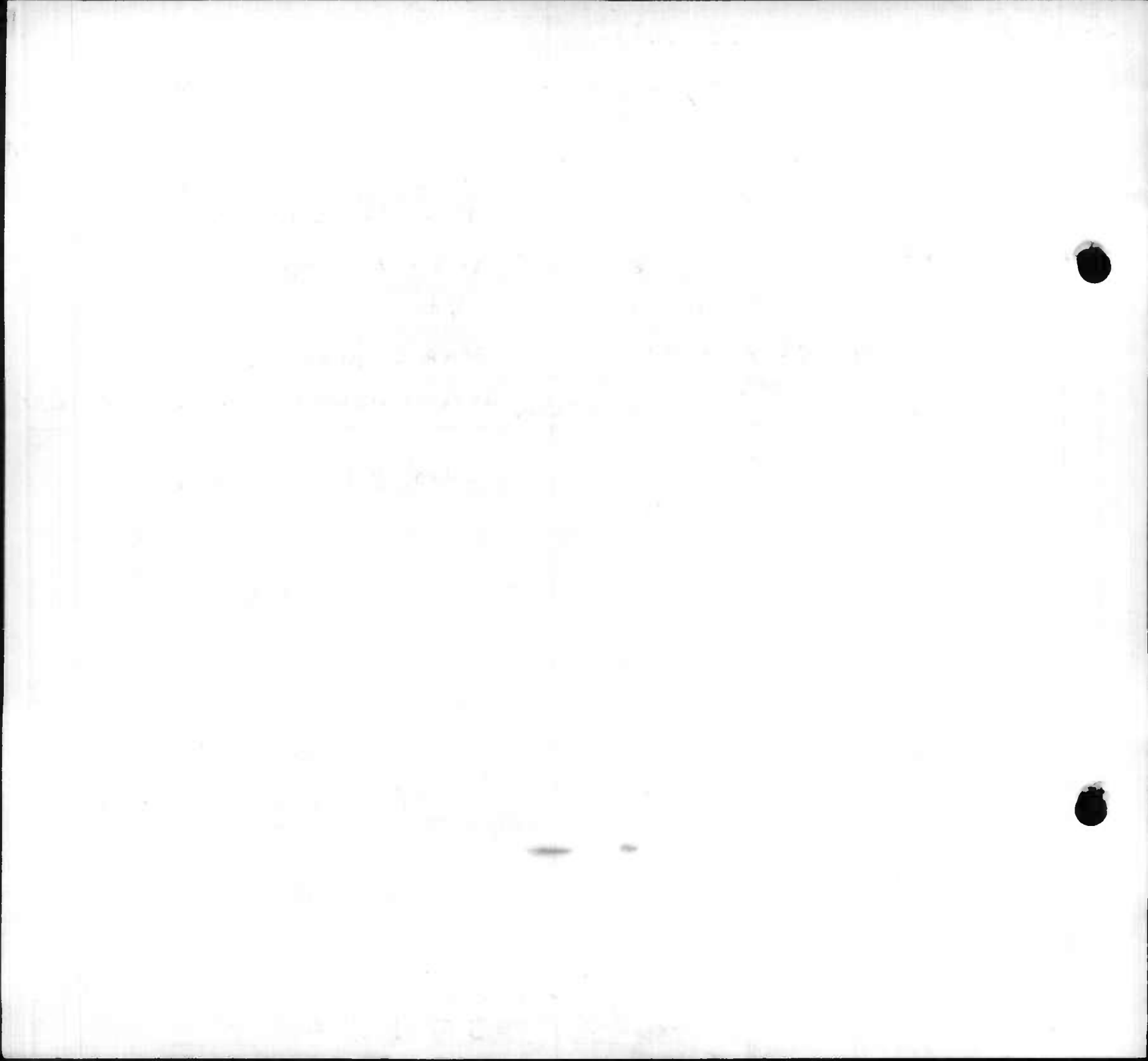
ADDRESS

AUG 11 1972

Dr. J. H. H. H.

Mr. J. H. H. H.

1129 N. Caroline St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07646

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07646

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Amie J. Carrington

2. DATE AND HOUR OF DEATH

8-6-72 1 30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Md. Gen. Hosp.
+ 8

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE B. COUNTY

Md.

1607

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

Baker St.

3026

5. SEX

F

6. RACE

Negro

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

7-1-23

9. AGE (In years last birthday)

49

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Nurse's Aide

10B. KIND OF BUSINESS OR INDUSTRY

Nursing Home

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Mc Kinley Pegram

14. MOTHER'S MAIDEN NAME

Sara Jones

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-20-7398

17. INFORMANT

R. John Carrington Same

ADDRESS

18. I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

Pulm. embolism

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Metastatic CA. of breast.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-18-1972 to 8-6-1972 that (I) (we) last saw the deceased alive on 8-6-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

A. N. Hall

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

8/6/72

23C. PHYSICIAN'S NAME (Type)

A. N. N. A.E.M.

23D. ADDRESS

Harry G. Hos 877 Linden Ave

24A. BURIAL CREMATION, REMOVAL (Specify)

Removal

24B. DATE

8-8-72

24C. NAME of CEMETERY or CREMATORY

Mt Zion Cemetery

24D. LOCATION

Dundas, Virginia

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 11 1972

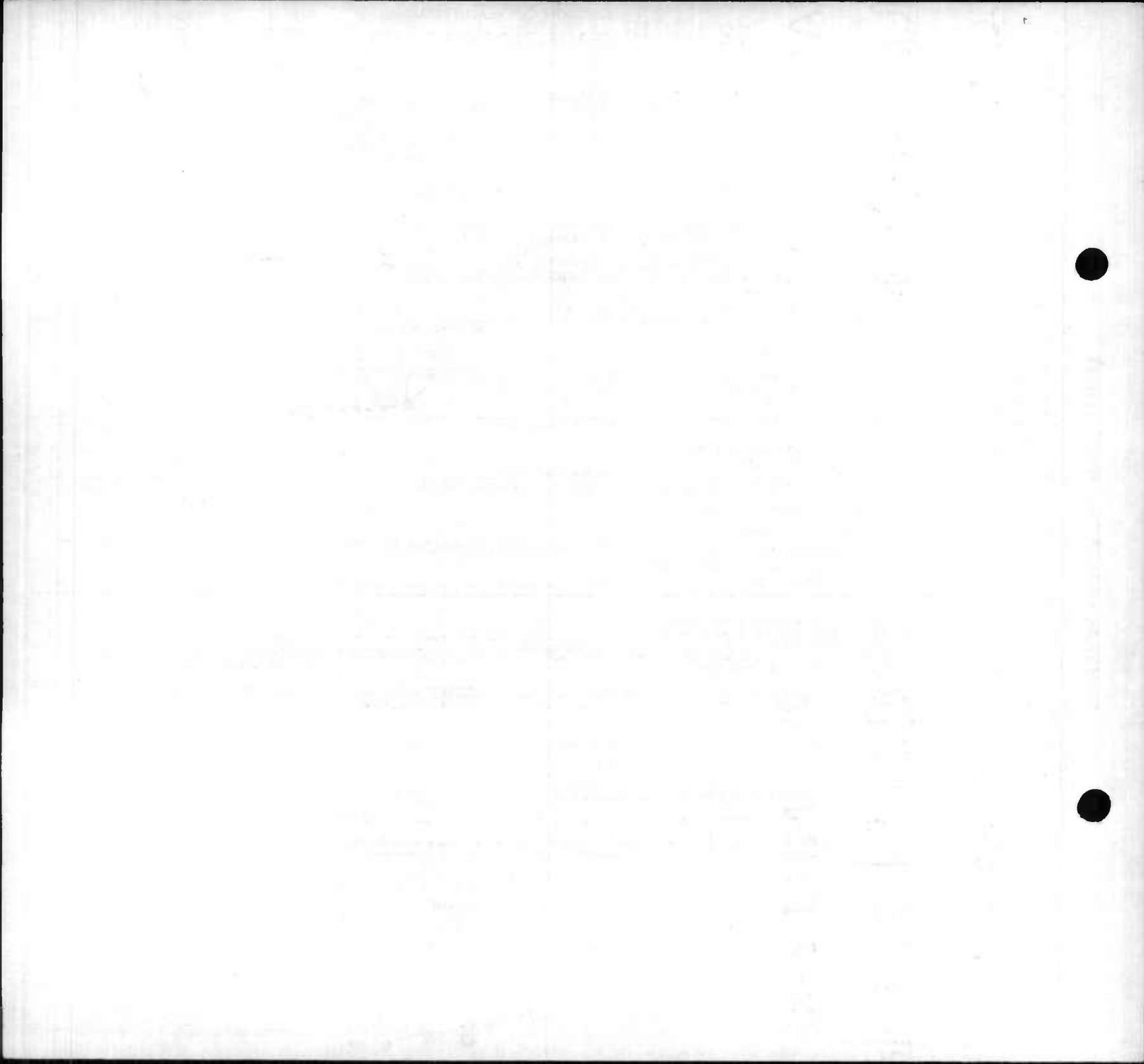
25B. NAME OF REGISTRAR

Ludwig W. Houston

25C. FUNERAL DIRECTOR

Phillips Funeral Home

ADDRESS



N-520

72 07647 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07647

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ALBERT NEWMUIS

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

39 PROVIDENT HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

August 4, 1972

4:20 P.

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

1504

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

7-31-1907

10. AGE (In years
lost birthday)

65

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1927 Herbert Street

11. BIRTHPLACE (State or foreign country)

Scranton P.A.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Newmuis

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lula Stevenson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

212-142323

18. INFORMANT

Doris Newmuis

ADDRESS

Same

19. E 826.10

CAUSE OF DEATH

Craniocerebral Injuries

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1900 Block Herbert Street

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.) 8-3-72 10:15 P. m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Pedestrian struck by bike

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

Deputy CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/5/72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-9-72

24C. NAME OF CEMETERY or CREMATORY

Ashburton Memorial Ch.

24D. LOCATION (City, town, or county)

Baltimore

Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 11 1972

25B. NAME OF REGISTRAR

Sidney W. Houston

25C. FUNERAL DIRECTOR

Ashburton Memorial Ch. 1727 N. Mount St.

ADDRESS

10

7-31-1917

Quarter 1A

James Lewis Thompson
John Thompson
John Thompson

James
8-1-17
John Thompson
John Thompson

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07648

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

VIOLA HENSON

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1403

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

10. AGE (in years
last birthday)

79

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1816 Brunt Street

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

216-18-0440

18. INFORMANT

ADDRESS

Henretta Jones 1910 Duval St.

19. 412.41

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 27, 1972

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/10/72

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county)

A. A. C.

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 11 1972

25B. NAME OF REGISTRAR

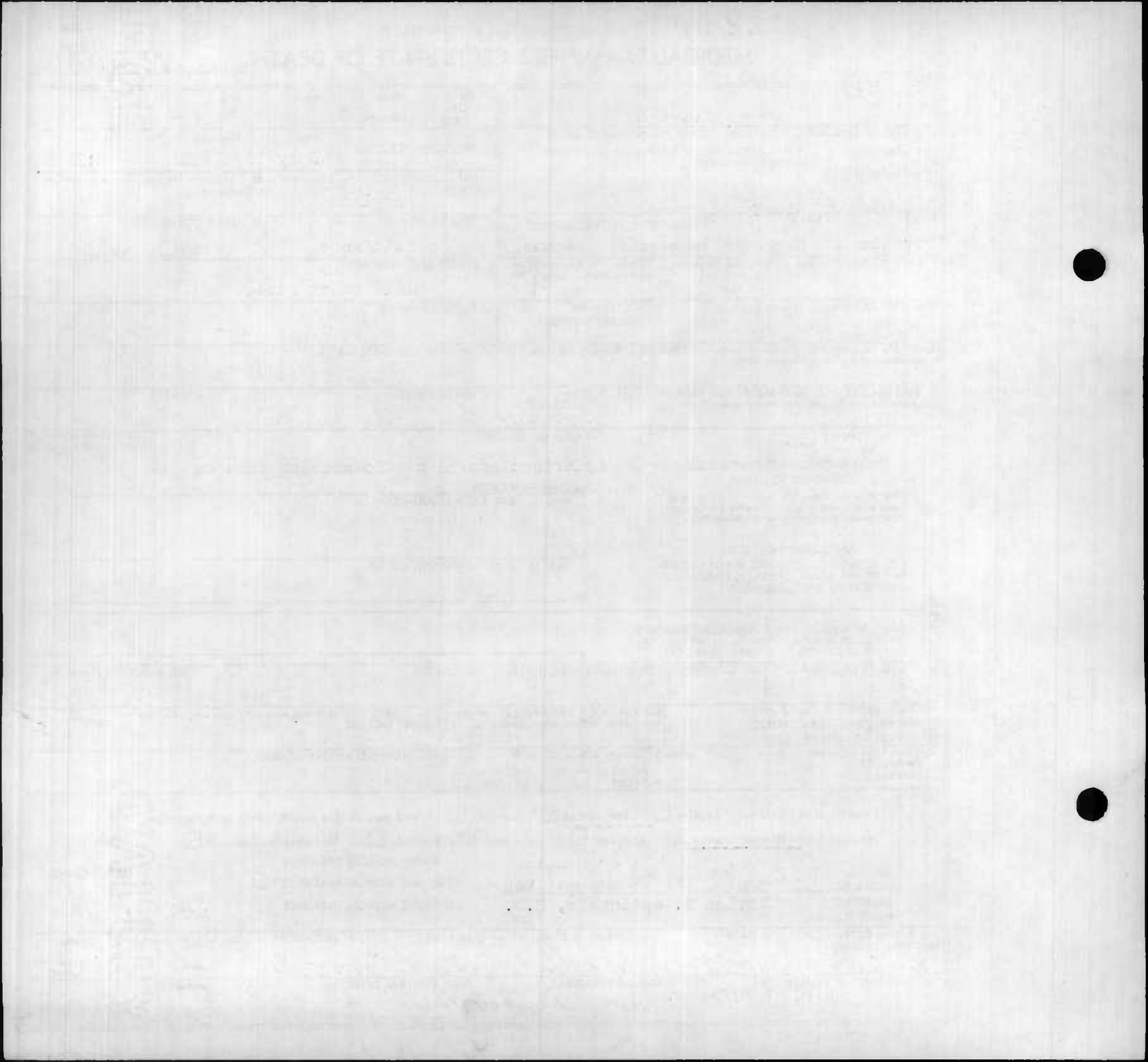
Andrew W. Hester

25C. FUNERAL DIRECTOR

Burlington Phillips

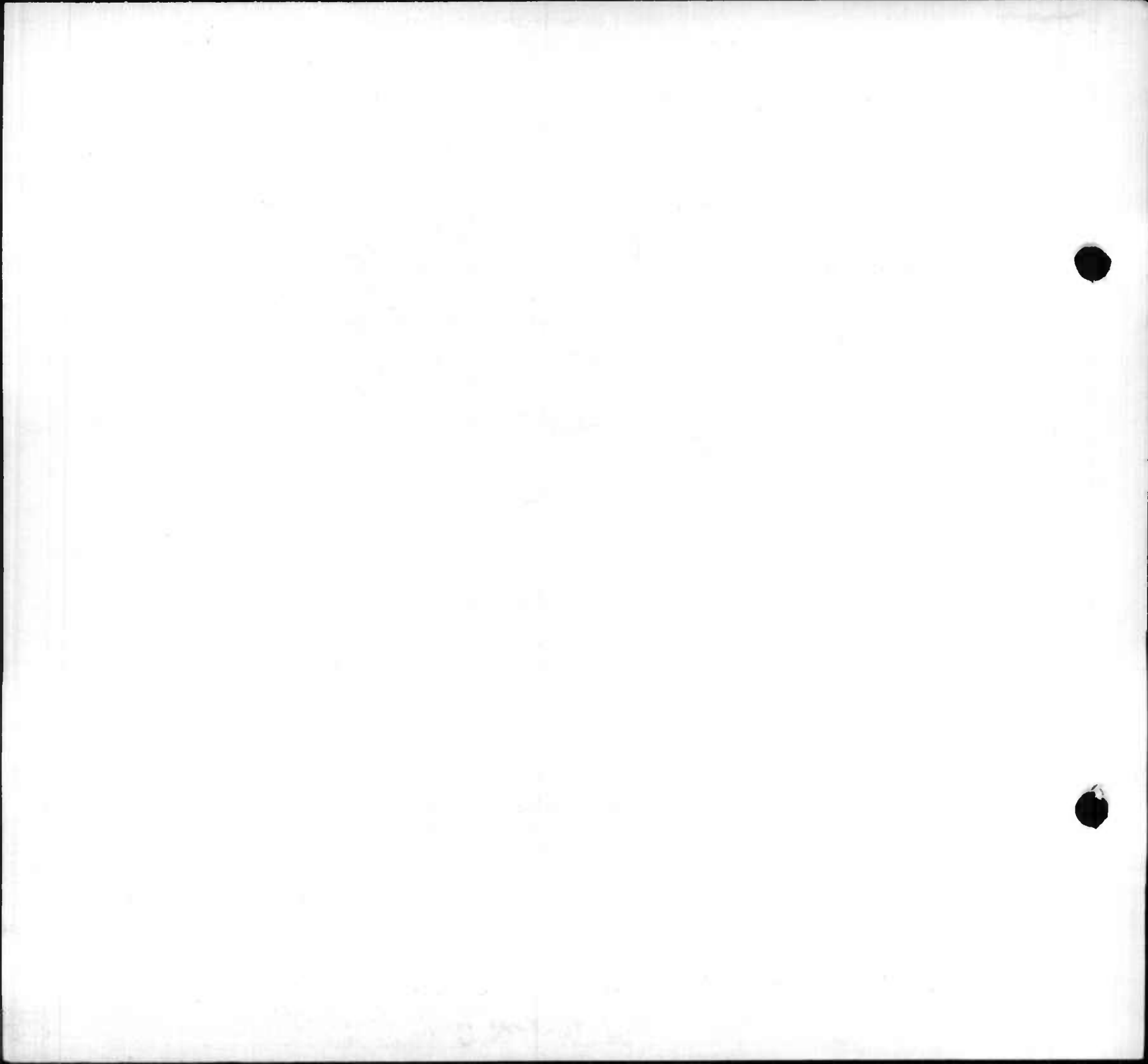
ADDRESS

1727 N. Mountz



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

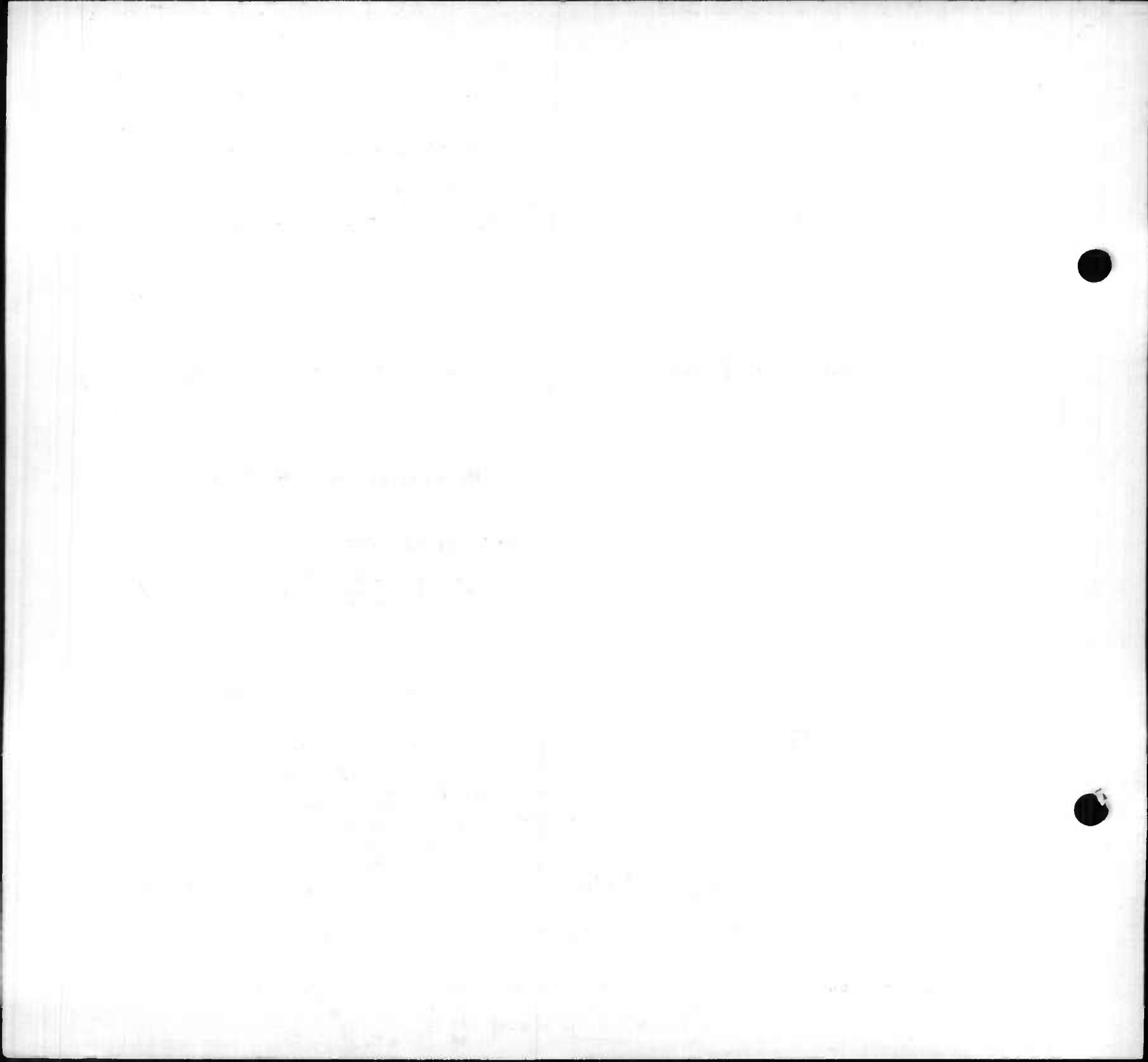
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Smith, James</i>		2. DATE AND HOUR OF DEATH <i>8/7/72</i> <i>1 4 P</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>MONTEBELLO STATE HOSP.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>1510</i>			
5. SEX <i>Male</i> 6. RACE <i>B</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-2-15</i> 9. AGE (In years last birthday) <i>57</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Contracting</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>	
13. FATHER'S NAME <i>Plummer Smith</i>		14. MOTHER'S MAIDEN NAME <i>Annie Drummond</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>704-16-3820</i>		17. INFORMANT <i>Ettel Smith</i> ADDRESS <i>Same</i>	
18. <i>162.1</i> I CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <i>Metastatic Carcinoma</i> <i>6 months</i> DUE TO, OR AS A CONSEQUENCE OF: <i>of the Lung to the Spine & Spinal Cord</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8-7-72</i> 19 to <i>8-7</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>8-7-</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Elsa M. Goris MD</i> DEGREE		23B. DATE SIGNED <i>8/7/72</i>		23C. PHYSICIAN'S NAME (Type) <i>ELSA M. GORIS - MD</i> DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-10-72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mtn. Brestigard</i> MD.	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 11 1972</i>		25B. NAME OF REGISTRAR <i>Dorothy S. Weston</i>		25C. FUNERAL DIRECTOR <i>William J. Phillips</i> ADDRESS <i>1727 N. Mount St.</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-200 1

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 07650 4</u>	
BIRTH NO. <u>72-11687</u>		72 07650			
1. NAME OF DECEASED (Type or Print) <u>Baby Girl Rice</u>			2. DATE AND HOUR OF DEATH <u>8-4-72</u> <u>3:10 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BON SECOURS HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1901</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1622 W. BALTIMORE ST.</u>		
5. SEX <u>F</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-4-72</u>	9. AGE (In years last birthday) <u>30</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>JAMES E. RICE</u>			14. MOTHER'S MAIDEN NAME <u>RUTHIE MAY JONES</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>771.1 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE <u>INTRAUTERINE ANOXIA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>PROLAPSE CORD.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Premature female - fast (775 gm)</u> <u>30 min.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner if maternal) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, room, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>spontaneous rupture of membrane</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>8-4</u> 19 <u>72</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>8.4.72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Suvimon Pongsiri M.D.</u>			23B. DATE SIGNED <u>8/4/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>SUVIMON PONGSIRI M.D.</u>			23D. ADDRESS <u>Bon Secours Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24B. DATE <u>8/6/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Bon Secours Hosp</u>	
24D. LOCATION <u>Baltimore, Md</u>		24E. DATE REC'D BY HEALTH DEPT. <u>AUG 11 1972</u>		24F. NAME OF REGISTRAR <u>Sylvia H. Weston</u>	
24G. FUNERAL DIRECTOR <u>3046</u>		24H. ADDRESS			



1
C-640

72 07651

BALTIMORE CITY HEALTH DEPARTMENT

72 07651

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REGISTERED OF MARYLAND-DEATH

BIRTH NO.

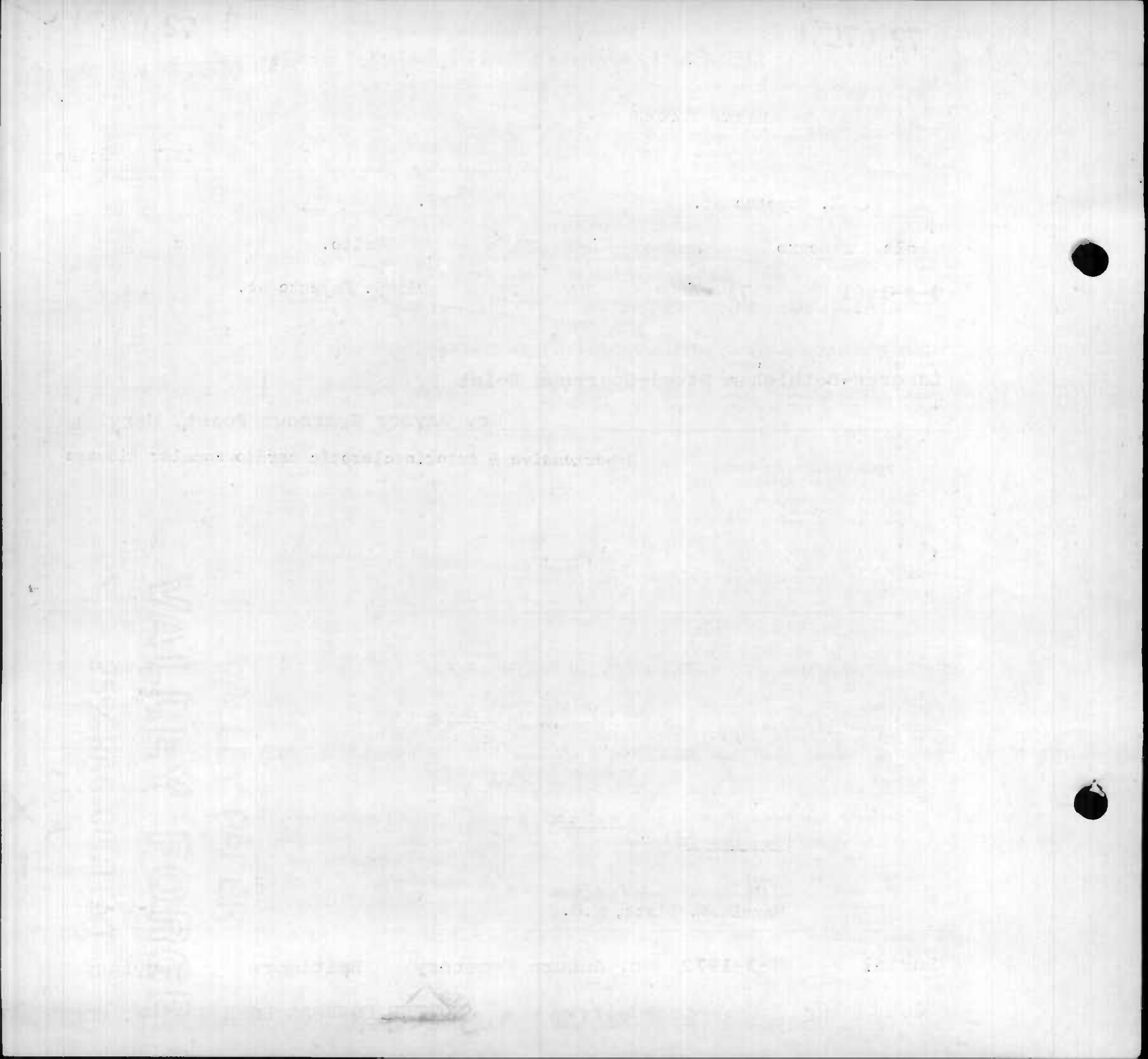
1. NAME OF DECEASED (Type or Print) HARRY CARROLL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 915 E. Fayette St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 9 1972 3:25p M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 302	
9. DATE OF BIRTH 3-9-1901		10. AGE (In years lost birthday) 71	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. STREET AND NUMBER 915 E. Fayette St.	
15. MOTHER'S MAIDEN NAME		16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer-Bethlehem Steel-Sparrows Point	
17. SOCIAL SECURITY NO.		18. INFORMANT Mr. Raynor Sparrows Point, Maryland	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		20. ADDRESS	

19. 412.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Hypertensive & arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
--	--	---	--

20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Marvin S. Platt, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-10-72					
---	--	--	--	--	--

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-3-1972		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1972		25B. NAME OF REGISTRAR Sidney Johnston		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AV	



F-260

72 07652

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07652

BIRTH NO.

REG. NO.

1. NAME OF DECEASED
(Type or Print)

WAYNE FISHER

2. DATE
OF
DEATHKnown ☐ Month
Estimated ☐

STATE OF MARYLAND - DEMI

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Sinai Hospital

3. DATE
PRONOUNCED DEADMonth Day Year Hour
8 6 1972 7:12p M.5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Md.

1513

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

8-28-1953

10. AGE (In years
last birthday)

18

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2704 Oswego Ave.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

O'Neal Fisher

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

student

14B. KIND OF BUSINESS OR INDUSTRY

school

15. MOTHER'S MAIDEN NAME

Maxine Matthews

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

217-64-5770

18. INFORMANT

ADDRESS

Mrs. Maxine Lee 2704 Oswego Avenue

19.

395.9

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Aortic stenosis, myocardial hypertrophy, pulmonary edema

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-7-72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-11-1972

24C. NAME of CEMETERY or CREMATORY

Church Of Deliverance

24D. LOCATION (City, town, or county) (State)

Lancaster

Virginia

25A. DATE REC'D BY HEALTH DEPT.

AUG 11 1972

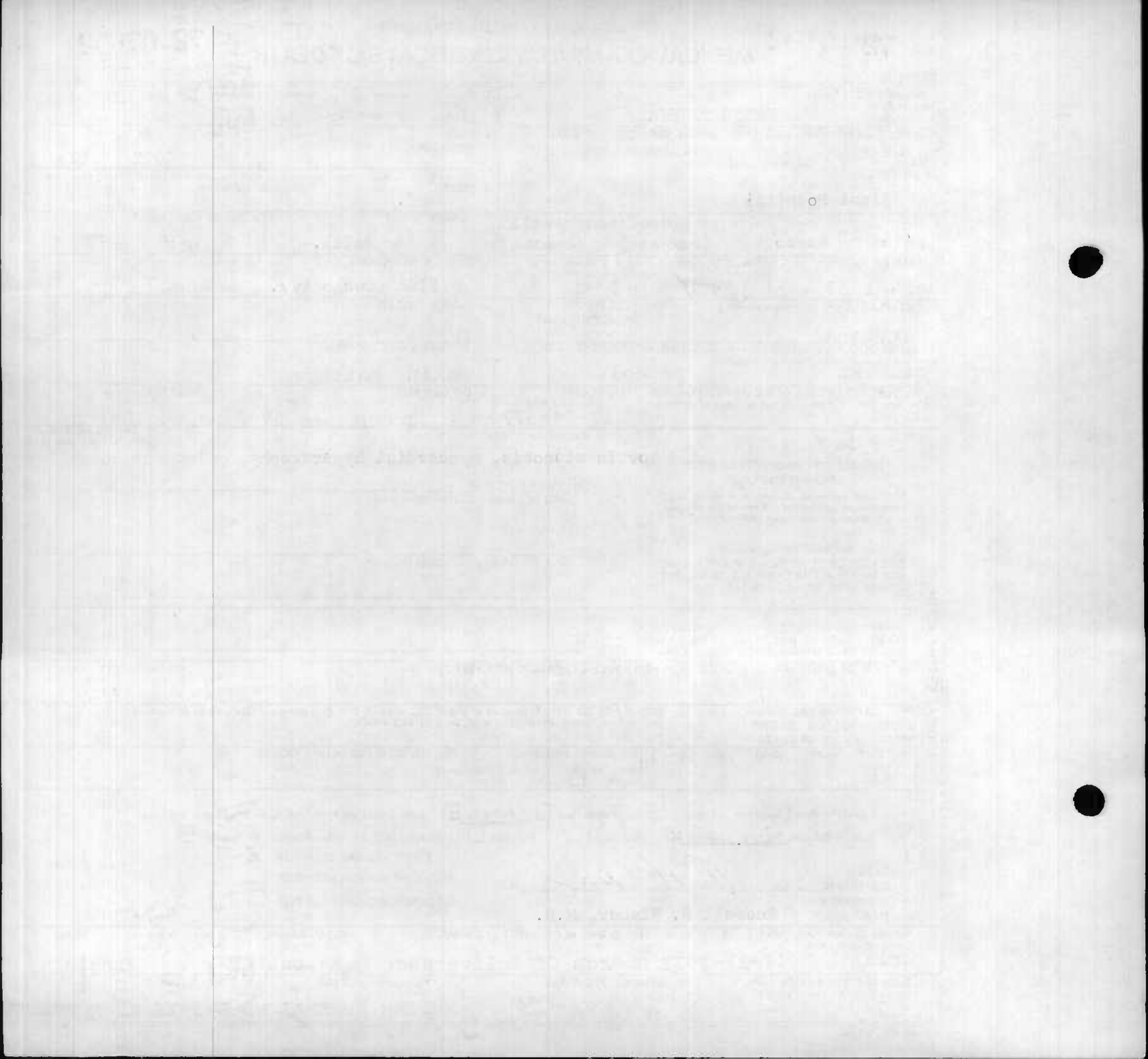
25B. NAME OF REGISTRAR

Sidney H. Boston

25C. FUNERAL DIRECTOR

ADDRESS

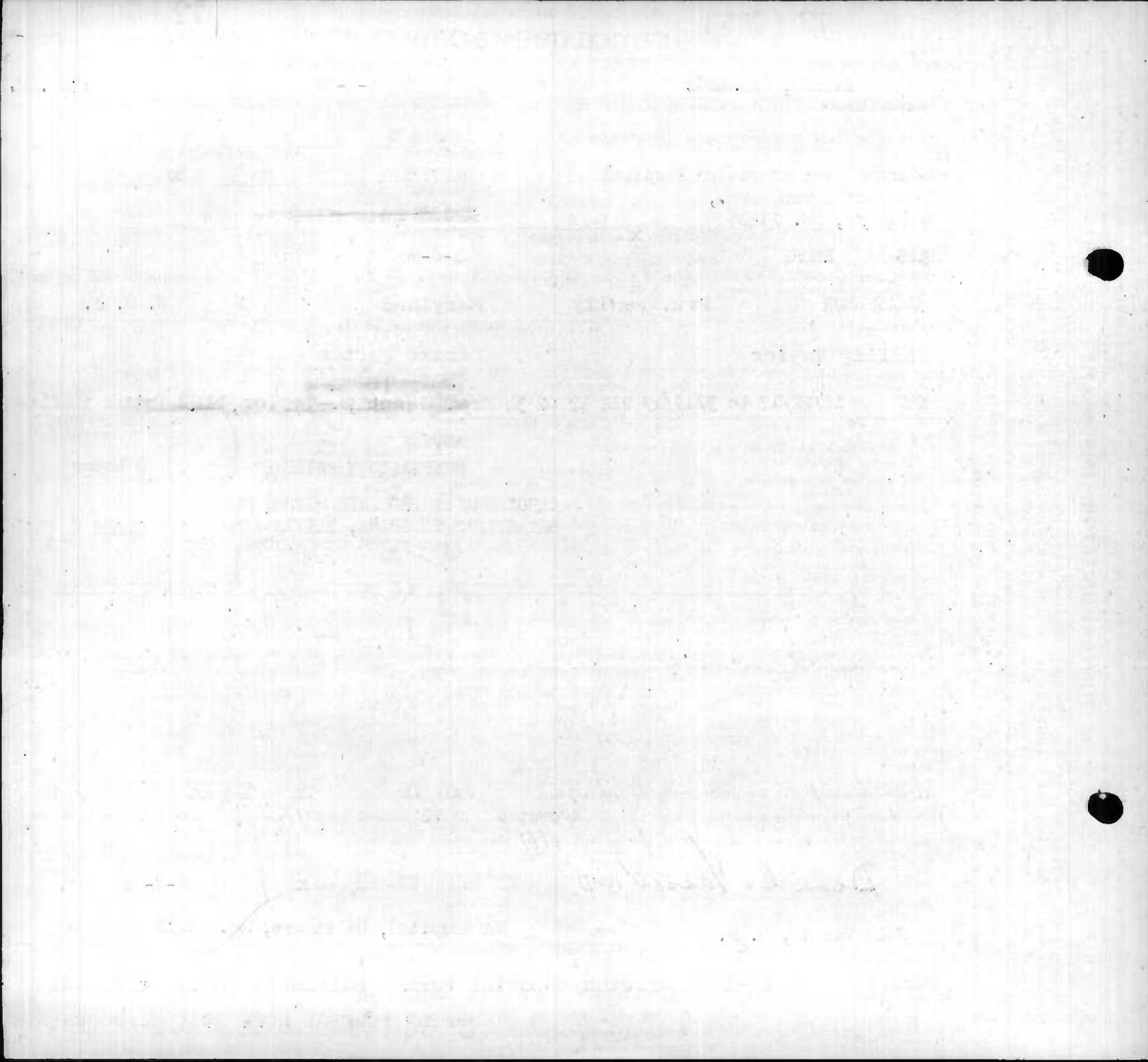
NUTTER FUNERAL HOME 3035 W. NORTH AV



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07653		REG. NO. 72 07653	
CERTIFICATE OF DEATH							
BIRTH NO.				1. NAME OF DECEASED (Type or Print) TAYLOR, CLARENCE			
2. DATE AND HOUR OF DEATH 8-6-72				STATE OF MARYLAND - DHMH 8:30P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1702			
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1102 Druid Hill Avenue							
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-96	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Phillip Taylor				14. MOTHER'S MAIDEN NAME Bertie Porter			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 11/22/17 to 3/19/19 212 12 02 34		17. INFORMANT Mrs. Janet G. Taylor, 1102 Druid Hill Ave			
18. 185X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE (A) IMMEDIATE CAUSE RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF: CARCINOMA OF PROSTATE WITH METASTASES TO SPINE, PELVIS AND FEMURS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) YEARS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 1972		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 14 19 72 to August 6 19 72 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 6 19 72 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (not) view the body after death.							
23A. SIGNATURE Dean L. Vassar M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-7-72	
23C. PHYSICIAN'S NAME (Type) DEAN VASSAR, M. D.				23D. ADDRESS VA Hospital, Baltimore, Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-10-1972		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1972		25B. NAME OF REGISTRAR Sidney B. B. B. B.		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE.			



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17-635

BALTIMORE CITY HEALTH DEPARTMENT

72 07654 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07654

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Albert Martin		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 8 Day 9 Year 72 Hour 12:30 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 2403 Lakeview		3. DATE PRONOUNCED DEAD Month 8 Day 9 Year 72 Hour 12:30 a. M.	
6. SEX male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1301	
9. DATE OF BIRTH 10-11-1901		10. AGE (In years lost birthday) 70 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baggage man		15. MOTHER'S MAIDEN NAME Emma Collins	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 422-01-3895	
18. INFORMANT Mrs. Jessie L. Martin		ADDRESS 2403 Lakeview Ave	
19. 141.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of tongue with metastases		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22G. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/9/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-12-1972	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1972		25B. NAME OF REGISTRAR Wendy M. Wooten	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AVENUE	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 07655</u>
BIRTH NO. <u>72 07655</u>		STATE OF MARYLAND - DEPT. OF HEALTH		
1. NAME OF DECEASED (Type or Print) <u>Yerby, Colin H.</u>		2. DATE AND HOUR OF DEATH <u>Aug. 6, 72</u> <u>6:30 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Balto.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>39 Provident Hosp.</u>		C. CITY OR TOWN <u>Balto.</u>		D. (INSIDE CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>4101 Rokeby Rd.</u>		
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-3-88</u>	9. AGE (in years last birthday) <u>83</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Henry Yerby</u>		
14. MOTHER'S MAIDEN NAME <u>Frances Mitchell</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>185-10-5618</u>		17. INFORMANT <u>Mrs. Colin F. Johnson-4101 Rokeby Road</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Hypertensive and arteriosclerotic cardiovascular disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1608</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Myxedema</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Uremia.</u> (C) <u>G-I bleeding</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>7/2</u> 19 <u>72</u> to <u>8/6</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/6</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>V. Chitraplee</u>		23B. DATE SIGNED <u>Aug. 6, 72</u>		23C. PHYSICIAN'S NAME (Type) <u>V. Chitraplee</u>
23D. ADDRESS <u>Provident Hosp.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>8-10-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Lawn & Lincoln Mem. pk</u>		24D. LOCATION (City, town, or county) (State) <u>Sharon Hill Pa.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 11 1972</u>		25B. NAME OF REGISTRAR <u>Sidney B. Johnson</u>		25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME 3035 W. NORTH AVE.</u>

Mr. B. J. Kelly
11-3-88

Northway

Mass.

Vermont

Hydrographic Survey

U.S. Navy

U.S. Navy

V. Hydrographic

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72 07656

BALTIMORE CITY HEALTH DEPARTMENT

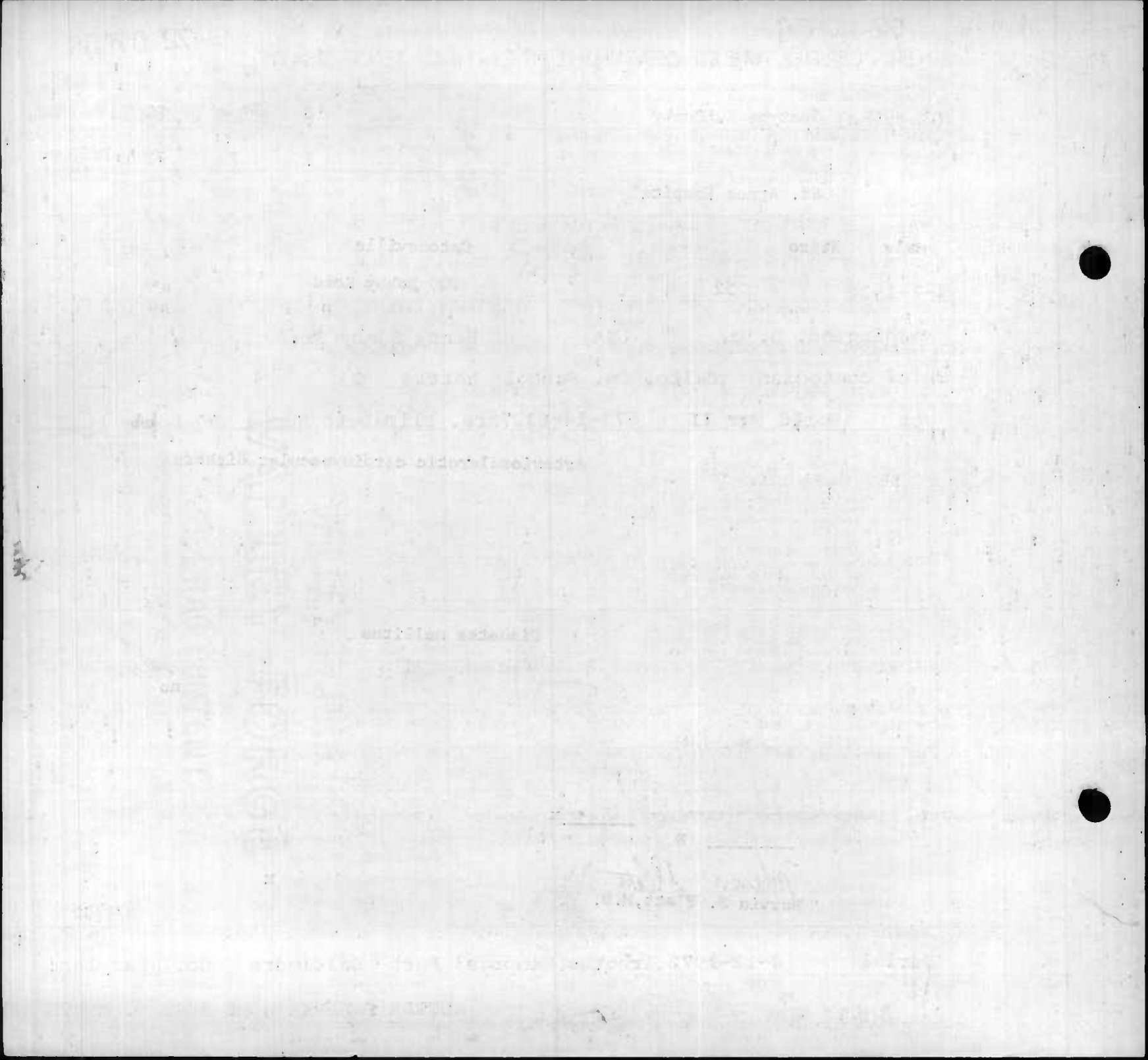
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72-07656

BIRTH NO.

1. NAME OF DECEASED (Type or Print) (Justine) Justyne E. Sumbly		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 8 Day 7 Year 72 Hour 7:50 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month 8 Day 7 Year 72 Hour 7:50 P.M.	
6. SEX male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTO C. CITY OR TOWN Catonsville D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 4-7-1920	10. AGE (In years lost birthday) 52	11. BIRTHPLACE (State or foreign country) Washington, D. C.	12. CITIZEN OF WHAT COUNTRY? USA
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) chief custodian		14B. KIND OF BUSINESS OR INDUSTRY Balto. Co. School	15. MOTHER'S MAIDEN NAME Mattie ?
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes World War II		17. SOCIAL SECURITY NO. 579-14-6327	18. INFORMANT Mrs. Elizabeth Sumbly
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.41 x 250.9 Arteriosclerotic cardiovascular disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diabetes mellitus	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22G. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Marvin S. Platt EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-12-1972	
24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1972		25B. NAME OF REGISTRAR Elizabeth Sumbly	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		25D. ADDRESS 3035 W. NORTH AVENUE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07657	
CERTIFICATE OF DEATH				REG. NO. 72 07657	
STATE OF MARYLAND-DHMH				72 07657	
BIRTH NO. 72 07657		2. DATE AND HOUR OF DEATH 8/9/72 7:35 P. M.			
1. NAME OF DECEASED (Type or Print) IRMA FRANCES LEWIS		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		A. STATE BALTIMORE MARYLAND 2864			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UPLANDS Home for Church Women 4501 Old Frederick Rd Baltimore Md 21229		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11/23/86		9. AGE (In years last birthday) 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) BALTIMORE Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William G. Siebold		14. MOTHER'S MAIDEN NAME CORA Webb			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-24-1225		17. INFORMANT Uplands Home for Church Women 4501 Old Fred. Rd	
18. 412, 41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Cerebrovascular thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1 Feb 1967 to 9 Aug 1972, that (I) (we) last saw the deceased alive on 8 Aug 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE M. Hallager, JMD				23B. DATE SIGNED 9 Aug 72	
23C. PHYSICIAN'S NAME (Type) DEGREE				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/72		24C. NAME OF CEMETERY or CREMATORY Druid Ridge	
24D. LOCATION (City, town, or county) Pikesville, Maryland		(State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1972		25B. NAME OF REGISTRAR Sidney W. Witzke		25C. FUNERAL DIRECTOR ADDRESS Witzke, 1630 Edmondson Avenue 21228	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 07658	
BIRTH NO. STATE OF MARYLAND-DHME							
1. NAME OF DECEASED (Type or Print) HARVEY, WILLIAM GUY				2. DATE AND HOUR OF DEATH AUGUST 9, 1972 10:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2107 ROLLING ROAD - 21207			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 01 23 96	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Messenger-Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY BANKING INSURANCE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HOWARD V HARVEY				14. MOTHER'S MAIDEN NAME MARY A BARTON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214 22 4909		17. INFORMANT ADDRESS ST AGNES HOSP RECORDS CATON & WILKENS AVES BALTO MD 21229			
18. 250,911 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Respiratory failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Cerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes Mellitus. ASCVD. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 08 08 19 72 to 08 09 19 72, that (X) (we) last saw the deceased alive on 08 09 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) view the body after death.							
23A. SIGNATURE Donald Tsai				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) DONALD TSAI, M.D. DONALD TSAI				23D. ADDRESS ST AGNES HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 08/11/72		24C. NAME OF CEMETERY OR CREMATORY CRESTLAWN CEMETERY		24D. LOCATION (City, town, or county) (State) MARRIOTTSTVILLE - HOWARD - MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1972		25B. NAME OF REGISTRAR Sydney H. Johnson		25C. FUNERAL DIRECTOR ADDRESS HARRY WITZKE, HOWARD COUNTY ELLICOTT CITY MD.			

HARVEY, WILLIAM SWAN

AUGUST 9, 1952

ST AGNES HOSPITAL

2107 FOLLING ROAD - 11507

NAME: CATHARTIAN

01 23 52

HARVEY, WILLIAM SWAN

HARVEY, WILLIAM SWAN

ST AGNES HOSPITAL
2107 FOLLING ROAD - 11507

08 03 52
08 03 52
08 03 52
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ST AGNES HOSPITAL

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 07659		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07659	
1. NAME OF DECEASED (Type or Print) Major Edna V.		2. DATE AND HOUR OF DEATH 8/6/72 11-32 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1301			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Aug 2, 1892		9. AGE (In years last birthday) 80 yr		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? American		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-22-4101		17. INFORMANT ADDRESS Wilhelmina Curley, 102 N. H. Han St., Balto. Md. 21229	
18. 410.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH (2) Congestive heart failure + pulmonary edema			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (1) Myocardial infarction			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: acute			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) X	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/5/1922 to 8/6/1922 that (I) (we) last saw the deceased alive on 8/6/1922 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bl. New		23B. DATE SIGNED 8/6/72		23C. PHYSICIAN'S NAME (Type) Bharat New	
23D. ADDRESS Maryland General Hospital, Baltimore		23E. NAME OF REGISTRAR			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-11-72		24C. NAME of CEMETERY or CREMATORY Urshaker Mem. Park	
24D. LOCATION Baltimore		24E. LOCATION (City, town, or county) (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
25D. ADDRESS		25E. ADDRESS 2222 N. North Ave			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07660

BIRTH NO.

STATE OF MARYLAND-DHMH

1. NAME OF DECEASED
(Type or Print)

FREDERICK WASHINGTON

2. DATE OF DEATH
Known ☐ Month Day Year Hour
Estimated ☐ M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)3. DATE PRONOUNCED DEAD Month Day Year Hour
8 6 1972 11:40a M.

00 1355 N. Stricker St.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md. B. COUNTY 1501

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

June 22, 1941

10. AGE (In years lost birthday)

31

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1355 N. Stricker St.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Mrs. J. William Washington

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mrs. J. Evelyn Smith

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, never unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

220-38-5029

18. INFORMANT

Mrs. Judith Boyd 17347 - Luthers

ADDRESS

19.

E887X

CAUSE OF DEATH

Subdural hemorrhage

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
yes22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
home22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
1355 N. Stricker St. 150122D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)
8-6-7222E. INJURY OCCURRED
a.m. WHILE AT WORK ☐ NOT WHILE AT WORK ☒22F. HOW DID INJURY OCCUR?
Apparently fell.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-7-72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-11-72

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem.

24D. LOCATION (City, town, or county) (State)

Brooklyn

Md

25A. DATE REC'D BY HEALTH DEPT.

AUG 11 1972

25B. NAME OF REGISTRAR

Audrey W. Wootton

25C. FUNERAL DIRECTOR

Joseph L. Rues 2222 W. North Ave

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07661

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07661

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHERRY, John T. Jr.

2. DATE AND HOUR OF DEATH

8/9/72

11:12 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

1711 Brentwood Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12/25/00

9. AGE (In years
last birthday)

71

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John T. Cherry Sr.

14. MOTHER'S MAIDEN NAME

Alice Spruell

15. Was Deceased Ever in U. S. Armed Forces
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

226-14-6130

17. INFORMANT

ADDRESS

Beatrice Cherry 1711 Brentwood Ave.

18. 410.91

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiorespiratory Arrest

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Possible MI, but?

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐
WorkNot While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/9 19 22 to 8/9 19 22
that (I) (we) last saw the deceased alive on 8/9 19 22 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Michael S. Katz, M.D.

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

8/9/72

23C. PHYSICIAN'S
NAME (Type)

Michael S. Katz, M.D.

DEGREE

23D. ADDRESS

The Johns Hopkins Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-14-72

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery

24D. LOCATION

Balto., Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 11 1972

25B. NAME OF REGISTRAR

Anthony J. March

25C. FUNERAL DIRECTOR

928 E. North Ave.

ADDRESS

17

CO

UNITED STATES

DEPARTMENT OF

THE ARMY

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72 07662 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHREG. NO. 72 07662
STATE OF MARYLAND-DEME

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Lillian Johnson

2. DATE AND HOUR OF DEATH

AUGUST 9 1972 9:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Ave.

Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1226 Ashland Ave. 21202 007

5. SEX

Female

6. RACE

Negro

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

1-14-14

9. AGE (in years
last birthday)

58

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Edna Taylor

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

20-12-2979

17. INFORMANT

4940 Eastern Ave. ADDRESS

BCH Records: Baltimore, Md. 21224

18.

15411

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

CARCINOMATOSIS

(B) DUE TO, OR AS A CONSEQUENCE OF:

CARCINOMA OF RECTUM

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

6-12 months

3 YEARS

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

10-2-69

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

CA RECTUM

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

NONE

21C. WHERE DID
INJURY OCCUR?

NONE

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

NONE

21E. INJURY OCCURRED

NONE

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

NONE

22. I certify that (I) (this hospital) attended the deceased from AUGUST 5 19 72 to AUGUST 9 19 72
that (I) (we) last saw the deceased alive on AUGUST 9 19 72 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. M. Urist, M.D.

DEGREE

Attending ☐Med. Director ☐Staff ☒

23B. DATE SIGNED

AUG 9, 1972

23C. PHYSICIAN'S
NAME (Type)

Dr. M. Urist M.D.

DEGREE

23D. ADDRESS

4940 Eastern Ave. Baltimore, Md. 21224
BALTIMORE CITY HOSPITALS24A. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-14-72

24C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

24D. LOCATION

Balto., Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 11 1972

25B. NAME OF REGISTRAR

Sidney B. Johnson

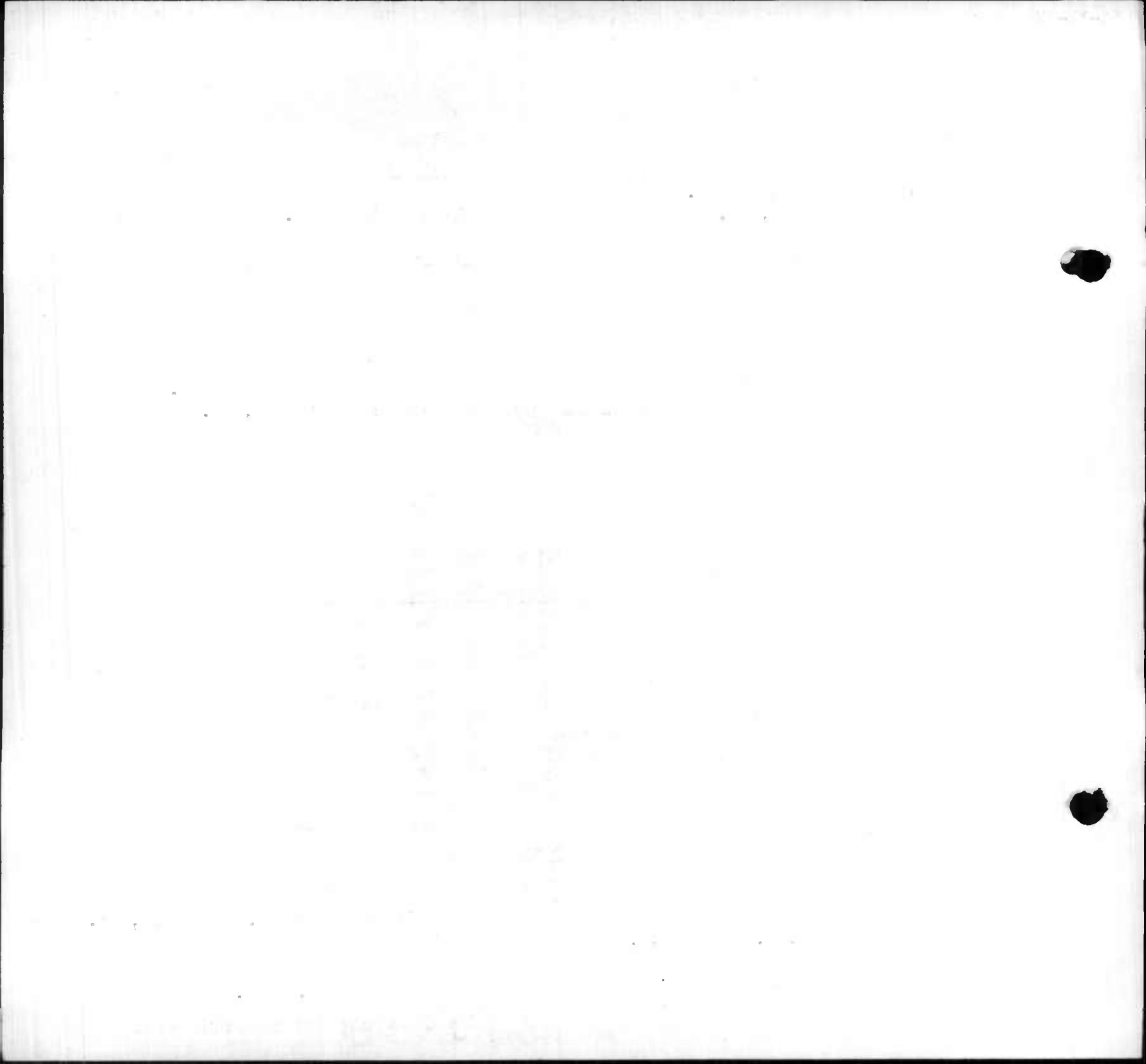
25C. FUNERAL DIRECTOR

Wm C. March 928 E North Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

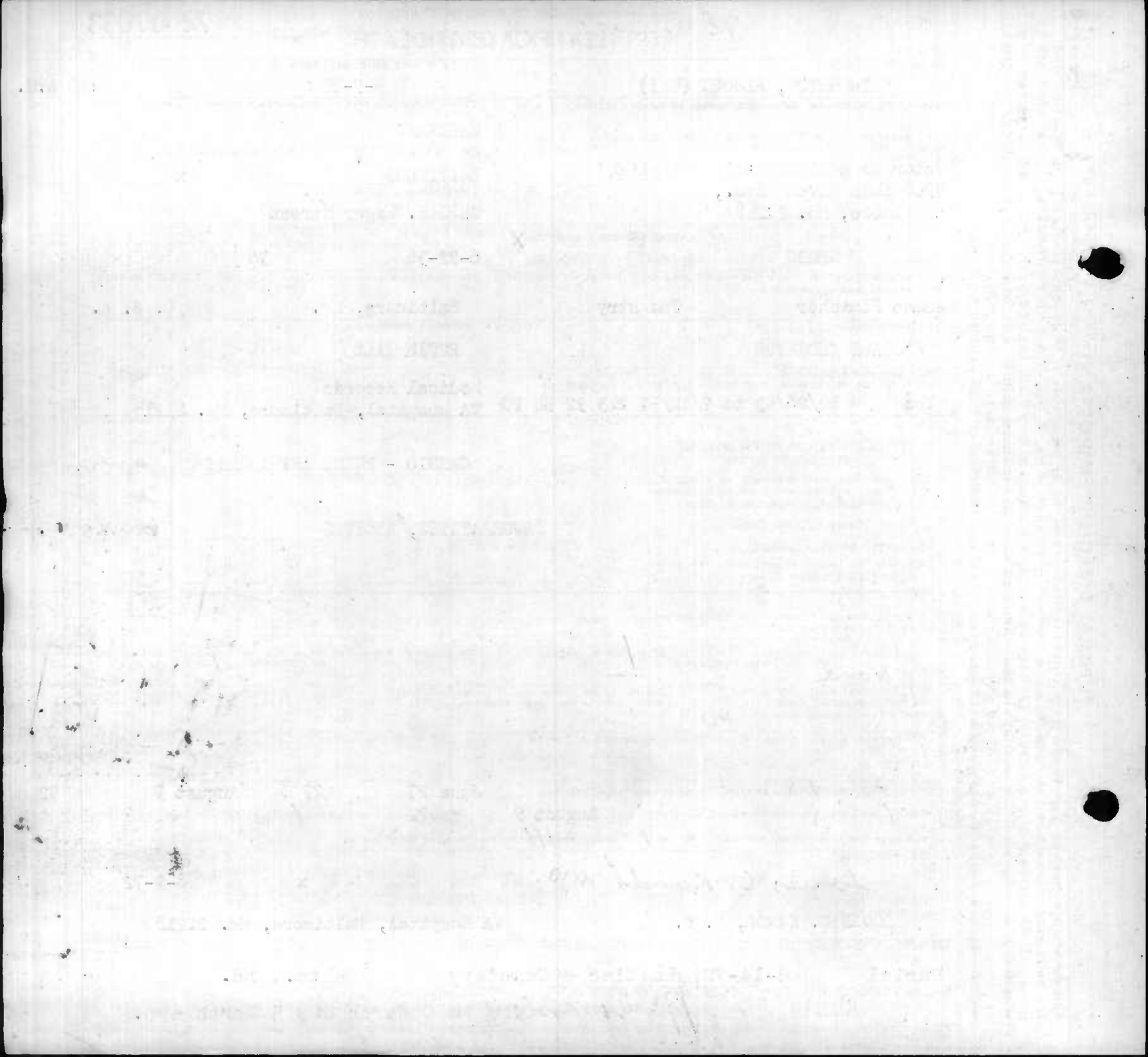
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07663 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 07663 STATE OF MARYLAND-DHMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) THORNTON, ELWOOD (NMI)		2. DATE AND HOUR OF DEATH 8-9-72 7:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 702 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2421 E. Eager Street		
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-22-36	9. AGE (In years last birthday) 36	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher		10B. KIND OF BUSINESS OR INDUSTRY Industry		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME EUSTACE THORNTON		
14. MOTHER'S MAIDEN NAME EFFIE WALL			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10/26/53 to 7/12/57		
16. SOCIAL SECURITY NO. 213 32 54 20			17. INFORMANT Medical Records VA Hospital, Baltimore, Md. 21218		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 577.01 CARDIO - PULMONARY ARREST 4 min -			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 wks.		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) PANCREATITIS, ASCITES 6 wks.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 27 19 72 to August 9 19 72 , that (I) (we) last saw the deceased alive on August 9 19 72 and that In (y) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (d/d/h/t) view the body after death.					
23A. SIGNATURE Louis C. Kandl M.D.				23B. DATE SIGNED 8-9-72	
23C. PHYSICIAN'S NAME (Type) LOUIS C. KANDL, M. D.				23D. ADDRESS VA Hospital, Baltimore, Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-14-72		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 11 1972			
25B. NAME OF REGISTRAR Wm C March		25C. FUNERAL DIRECTOR Wm C March 928 E North Ave.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07664

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES TRUESDALE, JR.

2. DATE OF DEATH Known ☒ Month Day Year Hour
Estimated ☐ August 10, 1972 M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
OR INSTITUTION

1806 Mullin Street

3. DATE PRONOUNCED DEAD Month Day Year Hour
August 10, 1972 7:30 A.M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

B. COUNTY

1502

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

1/9/1948

10. AGE (In years
last birthday)

24

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1806 Mullin Street

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Truesdale, Sr.

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mary Brice

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

17. SOCIAL
SECURITY NO.

-0-

18. INFORMANT

ADDRESS

Mrs. Mary Truesdale 1806 Mullin Street

19. 571.81

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Fatty metamorphosis of liver
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
Yes22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Marvin S. Platt, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 10, 1972

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/13/72

24C. NAME of CEMETERY or CREMATORY

Brightlight Bapt. Ch. Cem.

24D. LOCATION (City, town, or county) (State)

Lancaster, South Carolina

25A. DATE REC'D BY HEALTH DEPT.

AUG 11 1972

25B. NAME OF REGISTRAR

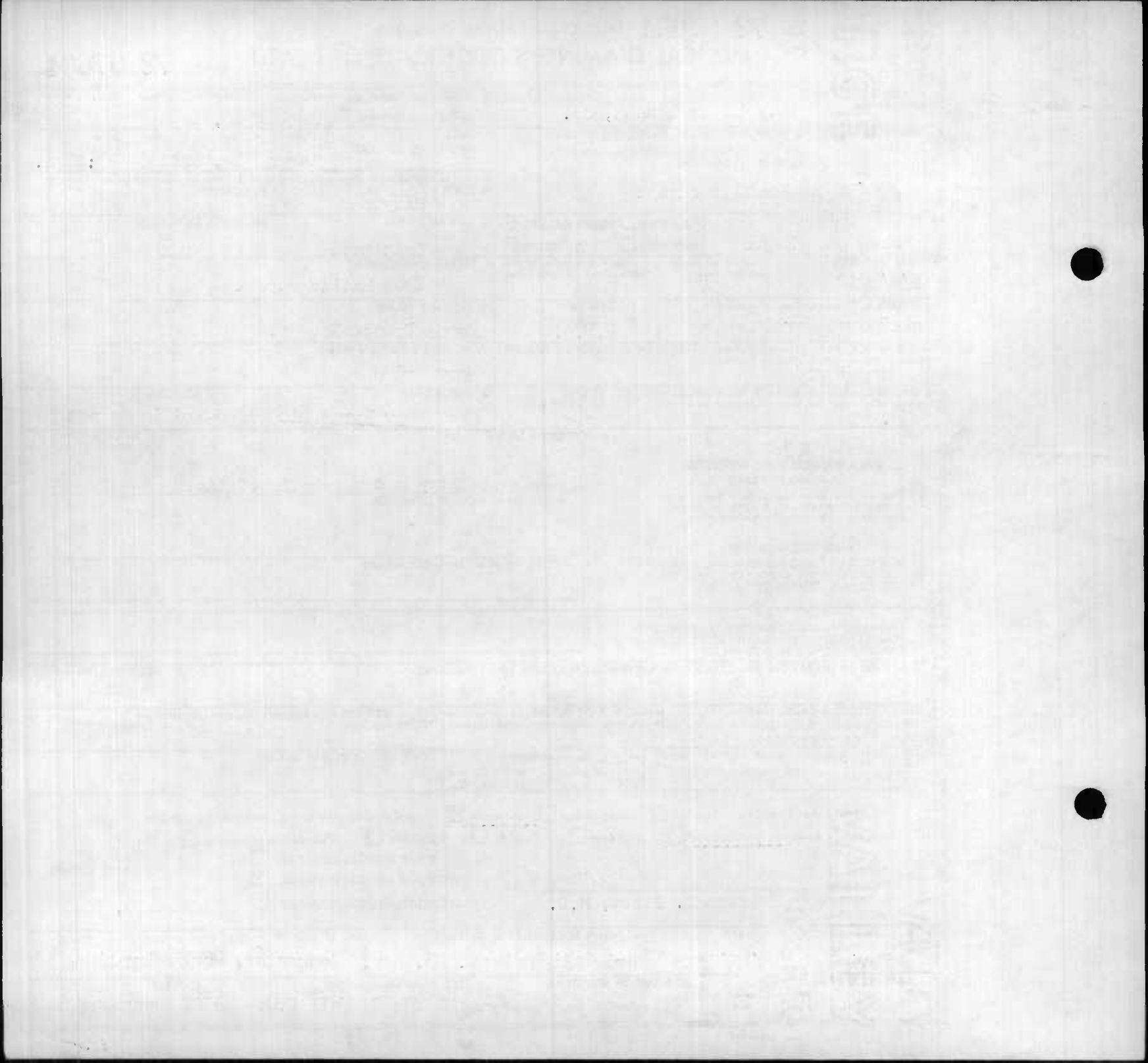
Sidney W. Houston

25C. FUNERAL DIRECTOR

MORTON & DYETT F.H.

ADDRESS

1701 Laurens St.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07665

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN BULLOCK, JR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 7 1972 2:05 a M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1703	
9. DATE OF BIRTH 12/17/53		10. AGE (In years lost birthday) 18	
11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Bullock, Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	
15. MOTHER'S MAIDEN NAME Geraldine Dixon		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.	
17. SOCIAL SECURITY NO. -0-		18. INFORMANT Mrs. Geraldine Bullock	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Craneo-cerebral injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Found 700 blk. W. Franklin St. 1703	
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 8-7-72 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Apparently beaten.		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-7-72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/11/72	
24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1972		25B. NAME OF REGISTRAR Sidney Houston	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens Street	

57

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 07666		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07666	
1. NAME OF DECEASED (Type or Print) SEIDENAR, CARL L.		2. DATE AND HOUR OF DEATH 8-9-72 9:00 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOY IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2759 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1410 KINGSWAY RD. 21218			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-99	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10B. KIND OF BUSINESS OR INDUSTRY Balto. Federal		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Cesare SEIDENAR		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service Yes WWI		16. SOCIAL SECURITY NO. 212-01-7201		17. INFORMANT Mrs. Carl L. Seidenar	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 441.21 HEMORRHAGIC SHOCK (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BLEEDING ABNORMALITY (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ABDOMINAL ANEURYSM		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 8/9/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ABDOMINAL ANEURYSM		20A. AUTOPSY (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 8/7/72 19 72 to 8/9 19 72 that (H) (we) last saw the deceased alive on 8/9 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James W. Isaac		23B. DATE SIGNED 8/10/72		23C. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-12-72		24C. NAME OF CEMETERY OR CREMATORY Parkwood	
24D. LOCATION Parkville		24E. CITY, TOWN, OR COUNTY Md.		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT. AUG 11 1972		25B. NAME OF REGISTRAR Sidney W. Johnson		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 1905 York Road Balto., Md. 21212	

10-11-1941

10-11-1941

10-11-1941

10-11-1941

10-11-1941

10-11-1941

10-11-1941

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07667

BIRTH NO.

STATE OF MARYLAND-DEMD

1. NAME OF DECEASED
(Type or Print)

WILLIAM CARMICHAEL, III

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

46 Lutheran Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

p. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

1606

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

12/24/1954

10. AGE (In years
last birthday)

17

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3039 Lanvale St.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

William Carmichael, Jr.

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Evelyn

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

17. SOCIAL
SECURITY NO.

-0-

18. INFORMANT

ADDRESS

Mr. William Carmichael, Jr.

Same

19.

CAUSE OF DEATH

Gunshot wound of head

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

house

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

3039 Lanvale St.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) 8-6-72 3:10 p

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Allegedly shot by friend.

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-7-72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/10/72

24C. NAME of CEMETERY or CREMATORY

Mount Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 11 1972

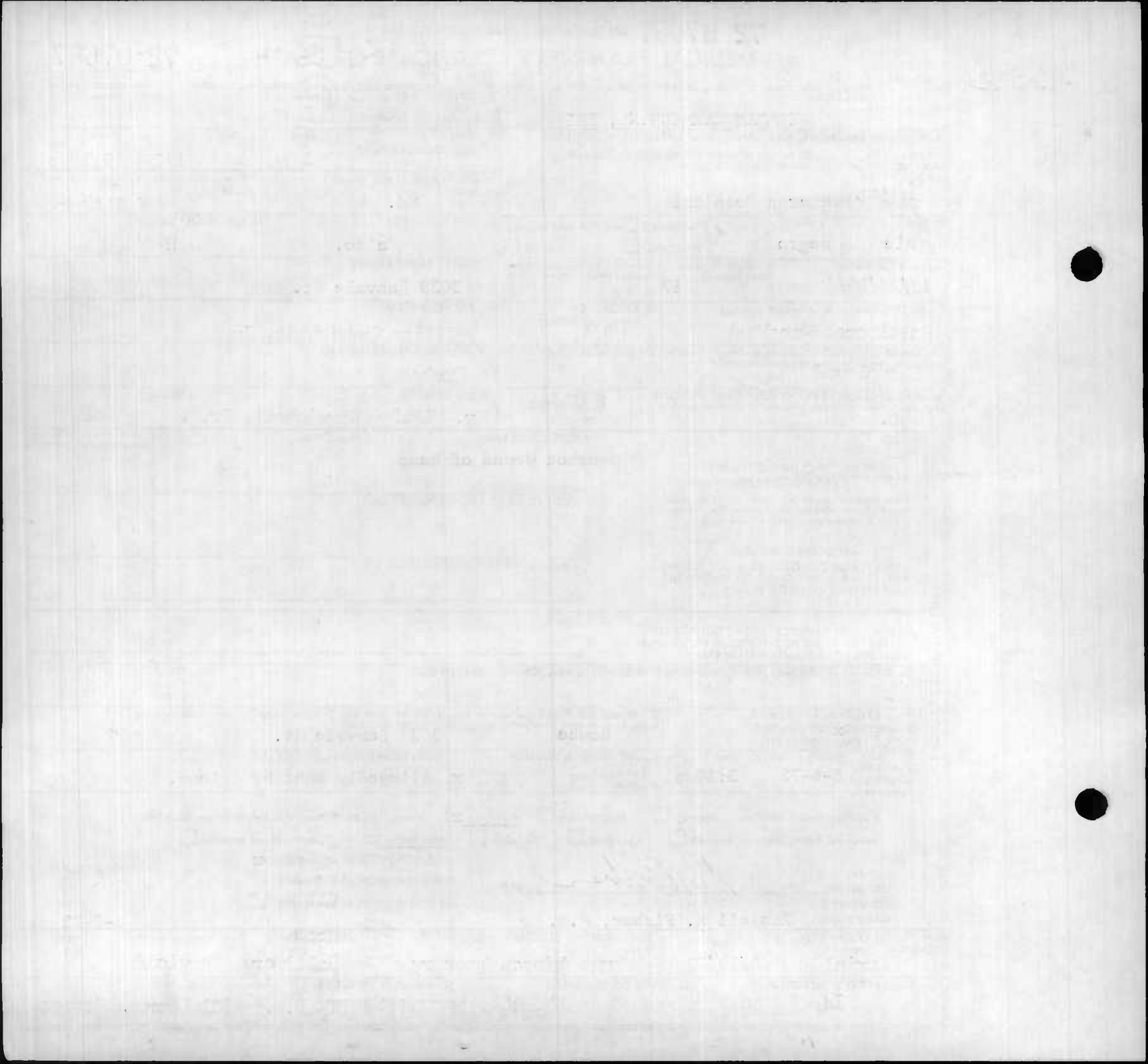
25B. NAME OF REGISTRAR

Sidney H. Houston

25C. FUNERAL DIRECTOR

MORTON & DYETT F.H. 1701 Laurens Street

ADDRESS



72 07668

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07668

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ANN JONES (Ann Ruth Jones)

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
OR INSTITUTION ADDRESS OR LOCATION)

MARYLAND GENERAL HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

August 7, 1972

6:50 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1302

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

4/21/1904

10. AGE (In years
last birthday)

68

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2213 Eutaw Place

11. BIRTHPLACE (State or foreign country)

Philadelphia, Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unk.

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cashier

14B. KIND OF BUSINESS OR INDUSTRY

Theatre

15. MOTHER'S MAIDEN NAME

Ann

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mr. Edward Wooden

308 N. Pulaski Street

19. E 814.17

CAUSE OF DEATH

Multiple Injuries

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
yes22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)
Street22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?
1000 blk. W. North Ave., west of Eutaw22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.) 8-7-72 4:10 P. m.22E. INJURY OCCURRED
WHILE AT ☐
WORK NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Pedestrian struck by car

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/8/72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/12/72

24C. NAME of CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION (City, town, or county)

Baltimore,

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 11 1972

25B. NAME OF REGISTRAR

Sidney W. Houston

25C. FUNERAL DIRECTOR

MORTON & DYETT F.H.

ADDRESS

1701 Laurens Street

N 946,832 000 3 0 0 1

(Ann Ruth Jones)

x

4/21/1904

Unk.

Philadelphia, Pennsylvania

U.S.A.

Ann

Theatre

Cashier

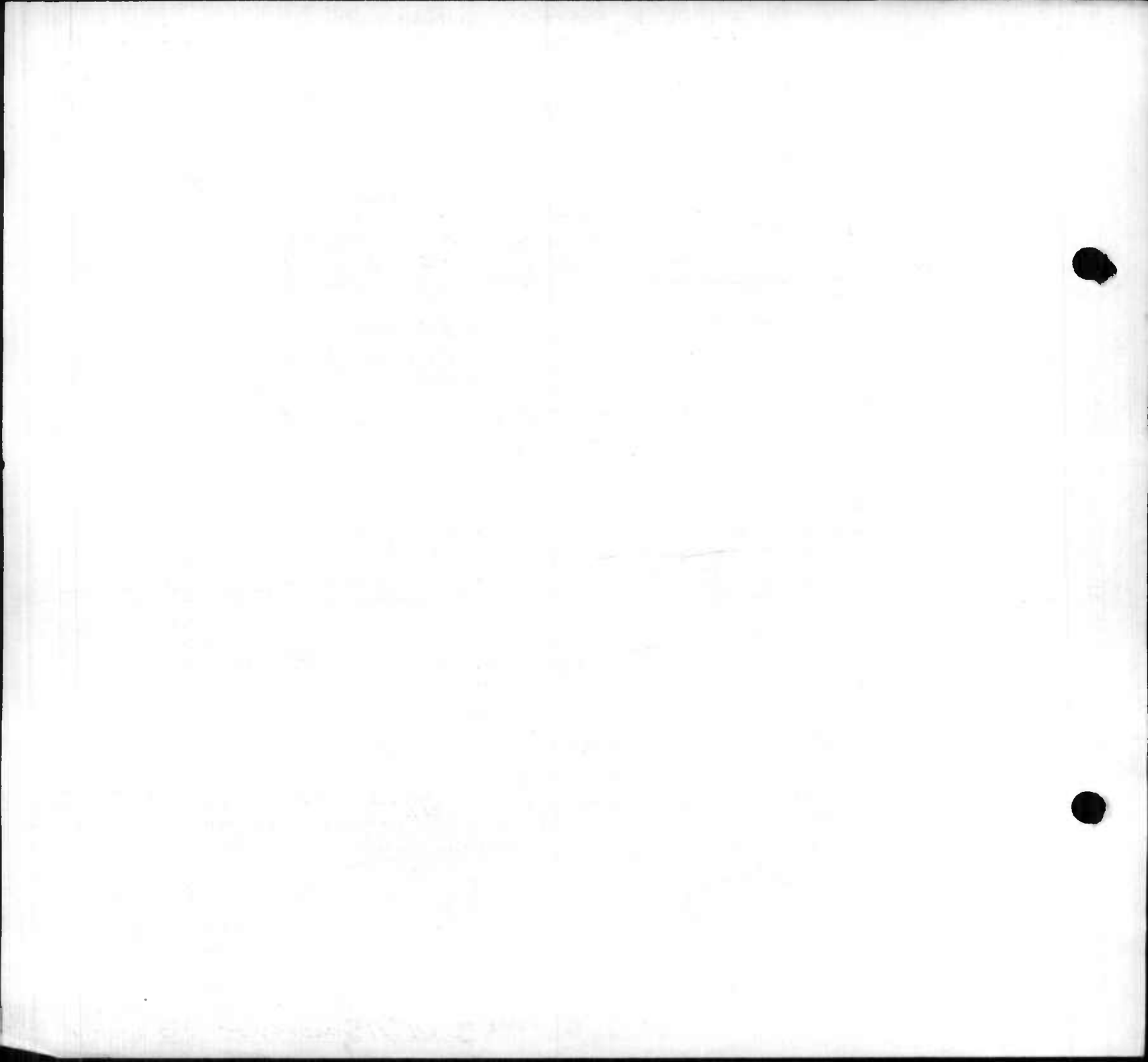
Mr. Edwards

No.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

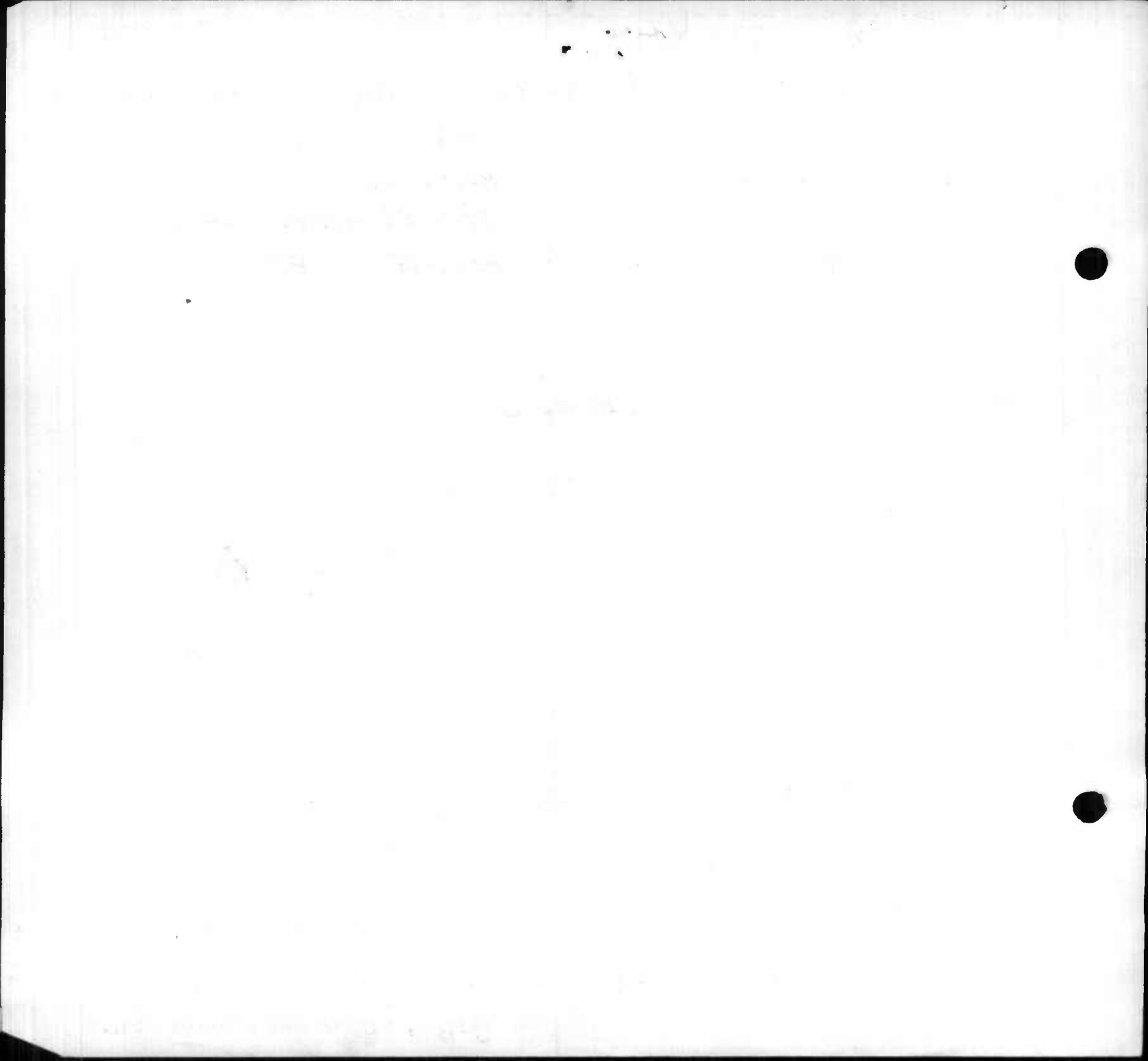
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 07669</u>	
BIRTH NO. <u>72 07669</u>		STATE OF MARYLAND-DEME			
1. NAME OF DECEASED (Type or Print) <u>ERNEST CLINE</u>		2. DATE AND HOUR OF DEATH <u>Aug. 11, 1972</u> <u>245</u> A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>35 Church Home & Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2608</u>			
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <u>3478 Mt. Pleasant Ave.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-03</u>	9. AGE (in years last birthday) <u>69</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
13. FATHER'S NAME <u>SAMUEL CLINE</u>		14. MOTHER'S MAIDEN NAME <u>CLARA Harris</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-07-7323</u>		17. INFORMANT ADDRESS	
18. <u>432.9</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE <u>Cardiorespiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) <u>Arteriosclerotic vascular disease</u>		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>7/6/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Coronary Thrombosis</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/10</u> 19 <u>72</u> to <u>8/11</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/11</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C. P. Vellu</u>		23B. DATE SIGNED <u>8/11/72</u>		23C. PHYSICIAN'S NAME (Type) <u>CECILE P. VELLU</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/14/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cathlamet Cem</u>	
24D. LOCATION <u>Baltimore Md</u>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Joseph M. Jannino</u>	
25C. FUNERAL DIRECTOR <u>263 S. Conkling</u>		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07670	
M-536 72 07670				STATE OF MARYLAND - DISTRICT	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Munter Mrs. Charlotte</i>		2. DATE AND HOUR OF DEATH <i>Aug 10 1972 6:45 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <i>Maryland</i>	
<i>2025 ST. FAYETTE STREET</i>		<i>BALTIMORE, MARYLAND 21223</i>		B. COUNTY <i>BALTO</i>	
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
				WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>02-01-85</i>		9. AGE (In years last birthday) <i>87</i>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>?</i>		<i>?</i>		<i>?</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>UNKNOWN</i>		16. SOCIAL SECURITY NO. <i>220-468374</i>		17. INFORMANT <i>PATIENT'S CHART, 2025 ST. FAYETTE STREET, BALTIMORE, MARYLAND</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Heat Stroke - EASVD and CVA</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>19 day</i>	
INTERCURRENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>00-00</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>7/21</i> 19 <i>72</i> to <i>8/10</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>8/10</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Chairman</i>		23B. DATE SIGNED <i>8/10/72</i>		23C. PHYSICIAN'S NAME (Type) <i>CHAIRMAN</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/14/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Lorraine Park Cemetery</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. NAME OF CEMETERY or CREMATORY <i>Baltimore, Maryland</i>		24F. LOCATION <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 14 1972</i>		25B. NAME OF REGISTRAR <i>...</i>		25C. FUNERAL DIRECTOR <i>Witzke, 1680 Edmondson Avenue 21228</i>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

STATE OF MARYLAND

1. NAME OF DECEASED (Type or Print) JOSEPH A. NAEGELE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 11, 1972		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 714 Glen Allen Drive		3. DATE PRONOUNCED DEAD Month Day Year August 11, 1972		Hour 9:28 P. M.
6. SEX Male		7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 9/8/02		10. AGE (In years last birthday) 69	11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF USA		13. FATHER'S NAME John A. Naegele		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired
15. MOTHER'S MAIDEN NAME unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 217-01-4811
18. INFORMANT J. Gordon Naegele, 714 Glen Allen Drive		19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Marvin S. Platt, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED August 12, 1972
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/72	24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	24D. LOCATION (City, town, or county) (State) Parkwood, Maryland
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Sidney Witzke		25C. FUNERAL DIRECTOR ADDRESS Witzke, 1630 Edmondson Avenue 21228

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07672
STATE OF MARYLAND-DHMH

BIRTH NO.

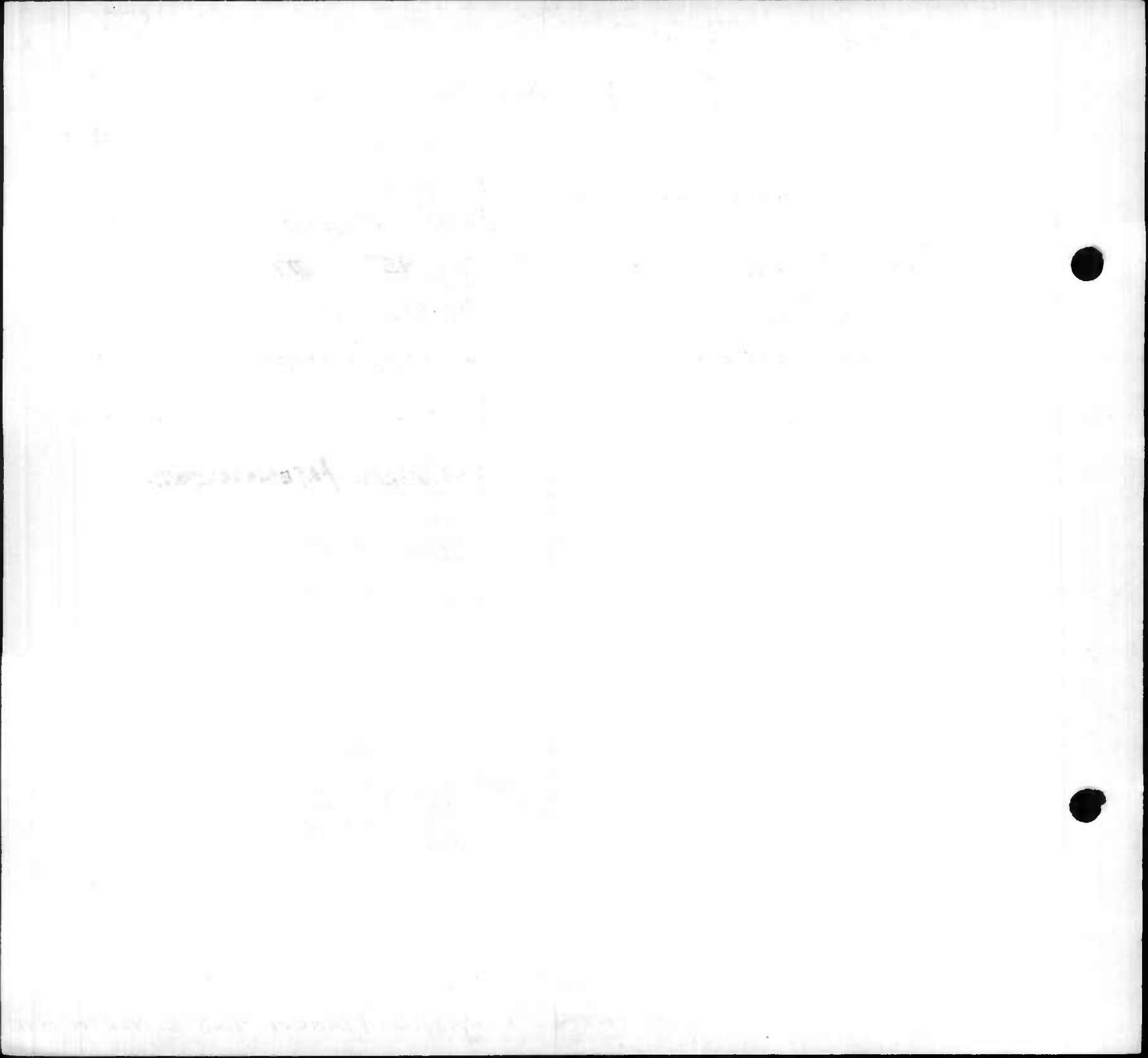
1. NAME OF DECEASED (Type or Print) Anthony JOHN CALLELA		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CITY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour August 1, 1972 4:35 P.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 4/21/20 AGE (In years 51 last birthday) 52		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years 51 last birthday) 52		E. STREET AND NUMBER 2821 O'Donnell Street	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Callela		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed	
15. MOTHER'S MAIDEN NAME Gumbult		16. KIND OF BUSINESS OR INDUSTRY General Contractor	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes War II		17. SOCIAL SECURITY NO. 214-14-8363	
18. INFORMANT Mrs Angela Dobert		ADDRESS 8036 Gough St.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Fatty metamorphosis of liver		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Fatty metamorphosis of liver			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 8/2/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/72	
24C. NAME OF CEMETERY or CREMATORY Gettysburg National Cem.		24D. LOCATION (City, town, or county) (State) Gettysburg, Pa.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Sister M. Winton	
25C. FUNERAL DIRECTOR Hartley Miller		ADDRESS 2332-34 Jefferson	

8-21-1972 - Correction form from Funeral Director - H. Miller, 2334 Jefferson St.
Balto., Md. & Discharge papers from U. S. Army HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 07673	
<div style="display: flex; justify-content: space-between;"> 72 07673 72 07673 </div>					
BIRTH NO. J-516					
1. NAME OF DECEASED (Type or Print) JENIFER (MARY) A. MAMIE			2. DATE AND HOUR OF DEATH August 12, 1972 5:40 pm		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 LUTHERAN HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1509 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3008 CHELSEA TERRACE		
5. SEX FEMALE	6. RACE COLOR	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/6/95	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME JOHN POTTER			14. MOTHER'S MAIDEN NAME (POTTER) MATILDA GROSS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT VERGIE CHRISTIAN 3008 CHELSEA
18. 43771 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 18.1 This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE ? CEREBRAL ARTERIOSCLEROSIS. DUE TO, OR AS A CONSEQUENCE OF: (B) ARTERIOCLEROTIC VASCULAR DISEASE. DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). SENESCENCE AS OLD AGE.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Famuyina Alufunsho M.D. B.S.			23B. DATE SIGNED 8-12-72		23C. PHYSICIAN'S NAME (Type) FAMUYINA ALUFUNSHO M.D. B.S.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 8-16-72		24C. NAME OF CEMETERY or CREMATORY BALTO NAT. CEM.
24D. LOCATION (City, town, or county) (State) BALTO., MD			25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		
25B. NAME OF REGISTRAR Shirley Horton			25C. FUNERAL DIRECTOR J.M.C. MARCH		
25D. ADDRESS 928 E. NORTH AVE					



E-542

72 07674

STATE OF MARYLAND - DEPT.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07674

BIRTH NO.

REG. NO. STATE OF MARYLAND - DEPT.

1. NAME OF DECEASED (Type or Print) Christine Ennells				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 8 Day 9 Year 72 Hour M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2012 Bryant Avenue				3. DATE PRONOUNCED DEAD Month 8 Day 9 Year 72 Hour 12:20 a. M.			
6. SEX female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1504	
9. DATE OF BIRTH June 1st 1909		10. AGE (In years last birthday) 63		11. BIRTHPLACE (State or foreign country) Portsmouth, VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Douglas Collins		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Jannie		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Jannie Wright		19. ADDRESS 1111 Park Apt. 1114		20. CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no		22. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22C. TIME (Month) (Day) (Year) (Hour)		22D. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22E. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. ACTUAL SIGNATURE Peter Lipkovic, M.D.		25. DATE SIGNED 8/9/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-14-72		24C. NAME OF CEMETERY or CREMATORY MT. Calvary Cem.		24D. LOCATION (City, town, or county) (State) Brooklyn, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Sidney Johnston		25C. FUNERAL DIRECTOR E. Brown		25D. ADDRESS O. Wilson 1000 Brantley Ave. Balto. Md.	

VALLEY BOILING

VALLEY BOILING

VALLEY BOILING

VALLEY BOILING

VALLEY BOILING

VALLEY BOILING

VALLEY BOILING

FUNERAL DIRECTOR: IMPORTANT

DR. KORNBLUM

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530		72-07675		BALTIMORE CITY HEALTH DEPARTMENT		72-07675	
BIRTH NO.		72-07675		REG. NO.		72-07675	
1. NAME OF DECEASED (Type or Print) EDWINA SMITH				2. DATE AND HOUR OF DEATH 6 Aug 72 6:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 624 STERLING STREET			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-27-29	9. AGE (In years last birthday) 43	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME JAMES HARRIS			14. MOTHER'S MAIDEN NAME GRACE TAYLOR		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service			16. SOCIAL SECURITY NO.		17. INFORMANT Geraldine Smith		ADDRESS SAME
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSE DISEASES OR CONDITIONS, if any, giving rise to the above, e.g., (A) stating the UNDERLYING CONDITION last				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction (C) DUE TO, OR AS A CONSEQUENCE OF: Pulmonary emboli		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 1 week 1 week, 2 days 2 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 8-6-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diabetic Gangrene		20A. AUTOPSY (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? None		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) None		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? None			
22. I certify that (I) (this hospital) attended the deceased from 8/3 19 72 to 8/6 19 72 that (I) (we) last saw the deceased alive on 8/6/72 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Paul F. Ryan				23B. DATE SIGNED 8/6/72		23C. PHYSICIAN'S NAME (Type) PAUL F. RYAN, M.D.	
23C. PHYSICIAN'S NAME (Type) PAUL F. RYAN, M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-12-72		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) Brooklyn Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Lidney Johnson		25C. FUNERAL DIRECTOR Eugene O. Wilson		ADDRESS 1000 Brimley Ave. Balto. Md.	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07676

BIRTH NO.

REG. NO.

STATE OF MARYLAND-DHMH

1. NAME OF DECEASED (Type or Print) Carrie Hicks		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 8 Day 8 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 418 N. Pine Street		3. DATE PRONOUNCED DEAD Month 8 Day 8 Year 72 Hour 3:03 a. M.	
6. SEX female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Mar. 9, 1907		10. AGE (In years last birthday) 55	
11. BIRTHPLACE (State or foreign country) D.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY None	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Arlene Williams		ADDRESS	

19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					

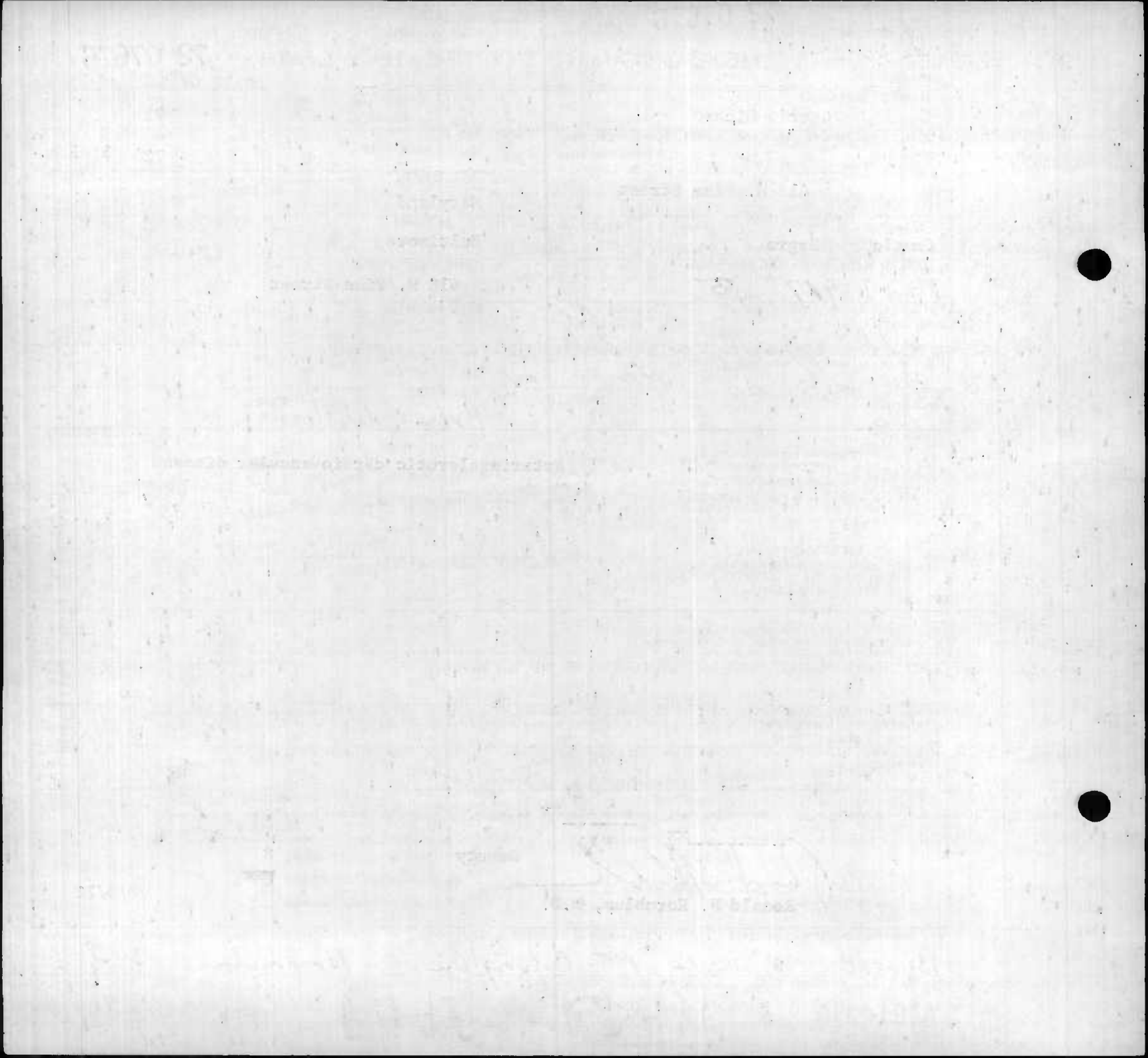
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Ronald N. Kornblum, M.D.** Deputy CHIEF MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) **Ronald N. Kornblum, M.D.** ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **8/8/72**

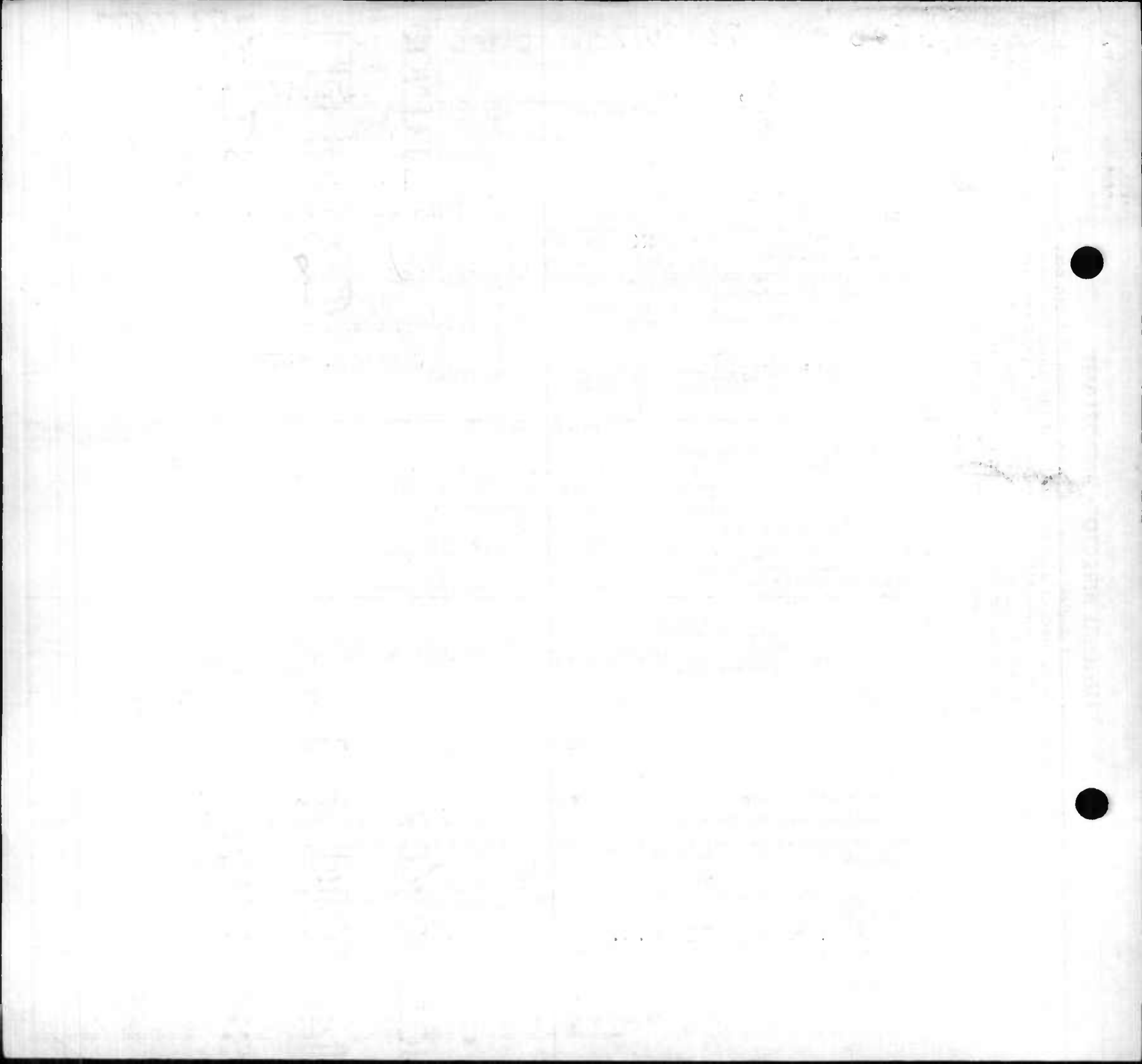
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-11-72		24C. NAME of CEMETERY or CREMATORY MT. Calvary Cem.		24D. LOCATION (City, town, or county) (State) Brooklyn Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Sidney W. Horton		25C. FUNERAL DIRECTOR Henry O. Wilson		ADDRESS 1000 Brantley Ave. Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07677	
72 07677 CERTIFICATE OF DEATH				STATE OF MARYLAND-DEMET	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
LOUD, ALLIE		08/07/72 5:41AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
JOHNS HOPKINS HOSPITAL		MARYLAND 703			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		2124 JEFFERSON STREET			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months; Days; If Under 24 Hrs. Hours; Min.
FEMALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	03/27/96	76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		None		Fredrick Co, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
DORSEY, ALBERT		JOHNSON, RUTH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No					
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory arrest 15"					
(B) DUE TO, OR AS A CONSEQUENCE OF: Metastatic adenocarcinoma of duodenum?					
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/7 to 8/7 19 72 that (I) (we) last saw the deceased alive on 8/7 19 72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Michael S. Katz, M.D.					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
DR MICHAEL KATZ M.D.				JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		8-10-72		Elroy Wilson	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 14 1972		Audrey Wilson		3 February 8. Wilson 1000 Brantly Ave. Balt. Md.	



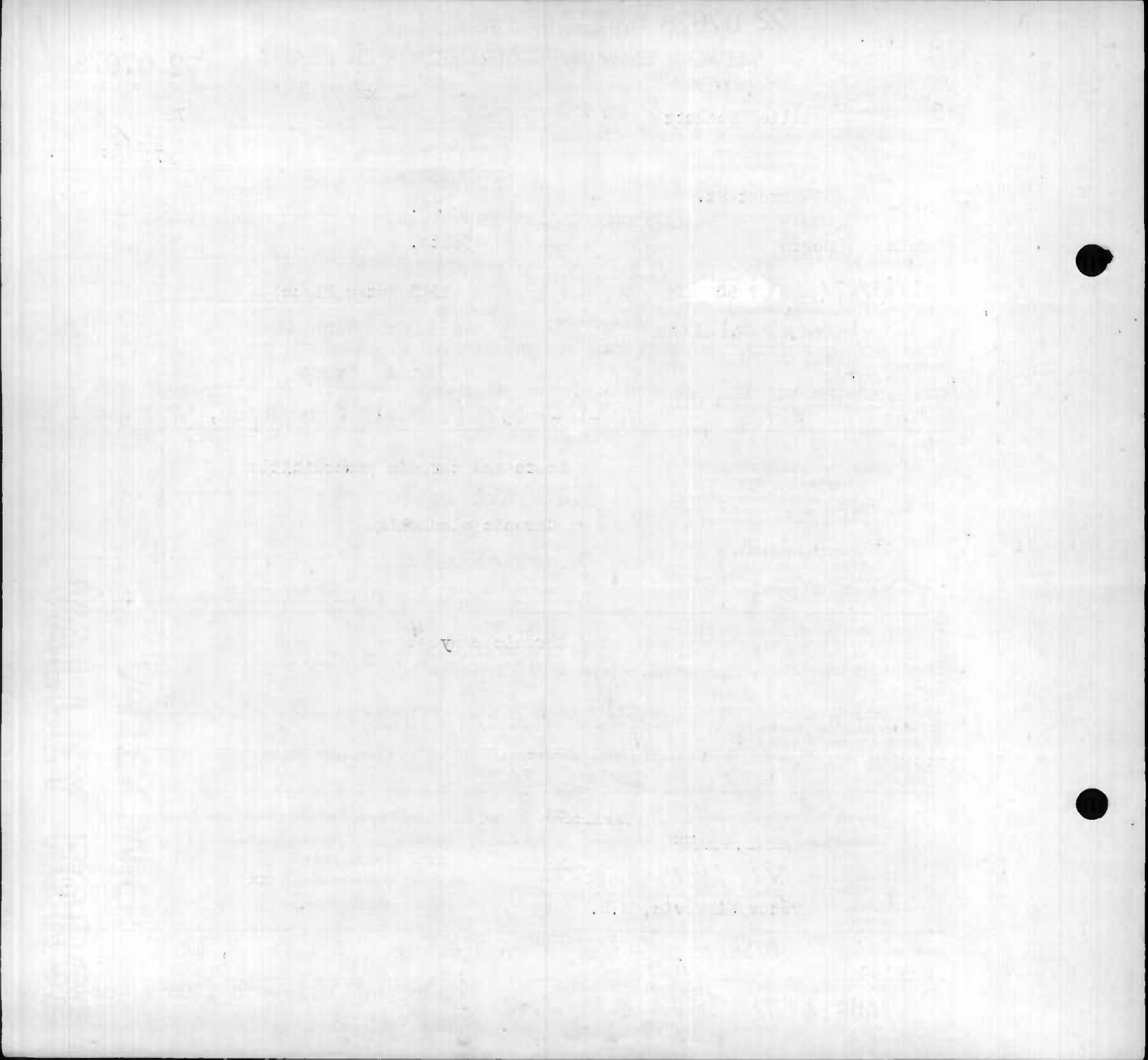
B-530

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07678

BIRTH NO. STATE OF MARYLAND-DEME

1. NAME OF DECEASED (Type or Print) William Bennett (Wm P Bennett)		2. DATE Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year 8 8 72		3. DATE PRONOUNCED DEAD Month Day Year 8 8 72		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) 00 1524 Brunt St.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1401	
6. SEX male		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH 1/23/27/		10. AGE (In years) 45	
11. BIRTHPLACE (State or foreign country) Georgetown S Carolina		12. CITIZEN OF U S A		13. FATHER'S NAME William Bennett		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		15. MOTHER'S MAIDEN NAME Rebecca Evans	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW2		17. SOCIAL SECURITY NO 726-16-9645		18. INFORMANT Mr David L Randolph, 4723 Hazel Ave		19. CAUSE OF DEATH 303.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute and chronic pancreatitis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic alcoholism (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic emphysema		20. DATE OF OPERATION 0	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/9/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/72		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town or county) (State) Baltimore, Md		25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972	
25B. NAME OF REGISTRAR Andrew Ingham		25C. FUNERAL DIRECTOR Adolphus Halstead		25D. ADDRESS 1206 W north Ave		25E. DATE SIGNED 8/9/72		25F. SIGNATURE Adolphus Halstead	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		72 07679		REG. NO.		72 07679	
1. NAME OF DECEASED (Type or Print)		Rose M. Sobieski (Hetmanski)		2. DATE AND HOUR OF DEATH		8/11/72 - 7:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE		B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Md BALTO		#21222		5300	
BALTO CITY HOSP.		4940 Eastern Ave, Baltimore, Md 21224		C. CITY OR TOWN		D. INSIDE CITY LIMITS?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER		8227 PARK HAVEN RD		21222					
5. SEX	6. RACE	7. MARRIED	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 1 Yr. Days	12. Under 24 Hrs. Hours	13. Under 24 Hrs. Min.
Female	Caucasian	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	8/15/91	80				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Retired				Maryland		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Martin Krolczyk		Catherine		No		217-03-6585		Leon Hetmanski - 8227 Park Haven Rd. 21222 Records: BCH-4940 Eastern Ave. 21224	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		BLEEDING CEREBRAL ANEURYSM		UNKNOWN			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		VASCULAR DISEASE					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from		8/12		19 72 to		8/11		19 72	
that (H) (we) last saw the deceased alive on		8/11		19 72		and that (in my) (our) opinion death occurred on the date			
and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.									
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. FUNERAL DIRECTOR ADDRESS	
Mark A. Lipton MD		8/11/72		Mark A. Lipton		4940 Eastern Ave/Baltimore, Md. 21224		George A. Weber - 705 S. Ann St. #21231	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		8/14/72		St. Stanislaus Cemetery		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR					
AUG 14 1972		Sidney H. Heston		George A. Weber					

10/21/8

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07680

BIRTH NO.

REG. NO.

STATE OF MARYLAND-DEPT

1. NAME OF DECEASED (Type or Print) Herman W. Conway		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1507 N. Patterson Park Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 22 72 2:55 a. M.	
6. SEX male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH	10. AGE (In years lost birthday) 70	11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	

MEDICAL CERTIFICATION	19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
	20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no
	22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?
--	---	----------------------------

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 7/22/72
ACTUAL SIGNATURE Charles S. Springate M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 8/10/72	24C. NAME of CEMETERY or CREMATORY Anatomy Bd.	24D. LOCATION (City, town, or county) (State) ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972	25B. NAME OF REGISTRAR Sidney Whiston	25C. FUNERAL DIRECTOR Cusan	ADDRESS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07681
STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ARTHUR STRADER

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

34 BON SECOURS HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

July 7, 1972

12:55 P.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

1903

6. SEX

Male

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

10. AGE (In years
lost birthday) 49If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1625 W. Pratt Street

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19.

E98019

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Overdose of alcohol and barbiturate

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)
Street ?22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Found-1800 Block W. Street

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) 7-6-72 P.M.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Ingested alcohol and barbiturate

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

Deputy
M.D.CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/8/72

24A. BURIAL (CREMATION)
REMOVAL (Specify)

24B. DATE

8/10/72

24C. NAME of CEMETERY or CREMATORY

Anatomy Bd.

24D. LOCATION

UNIVERSITY MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.

AUG 14 1972

25B. NAME OF REGISTRAR

Sidney Kornblum

25C. FUNERAL DIRECTOR

S. Kornblum

ADDRESS

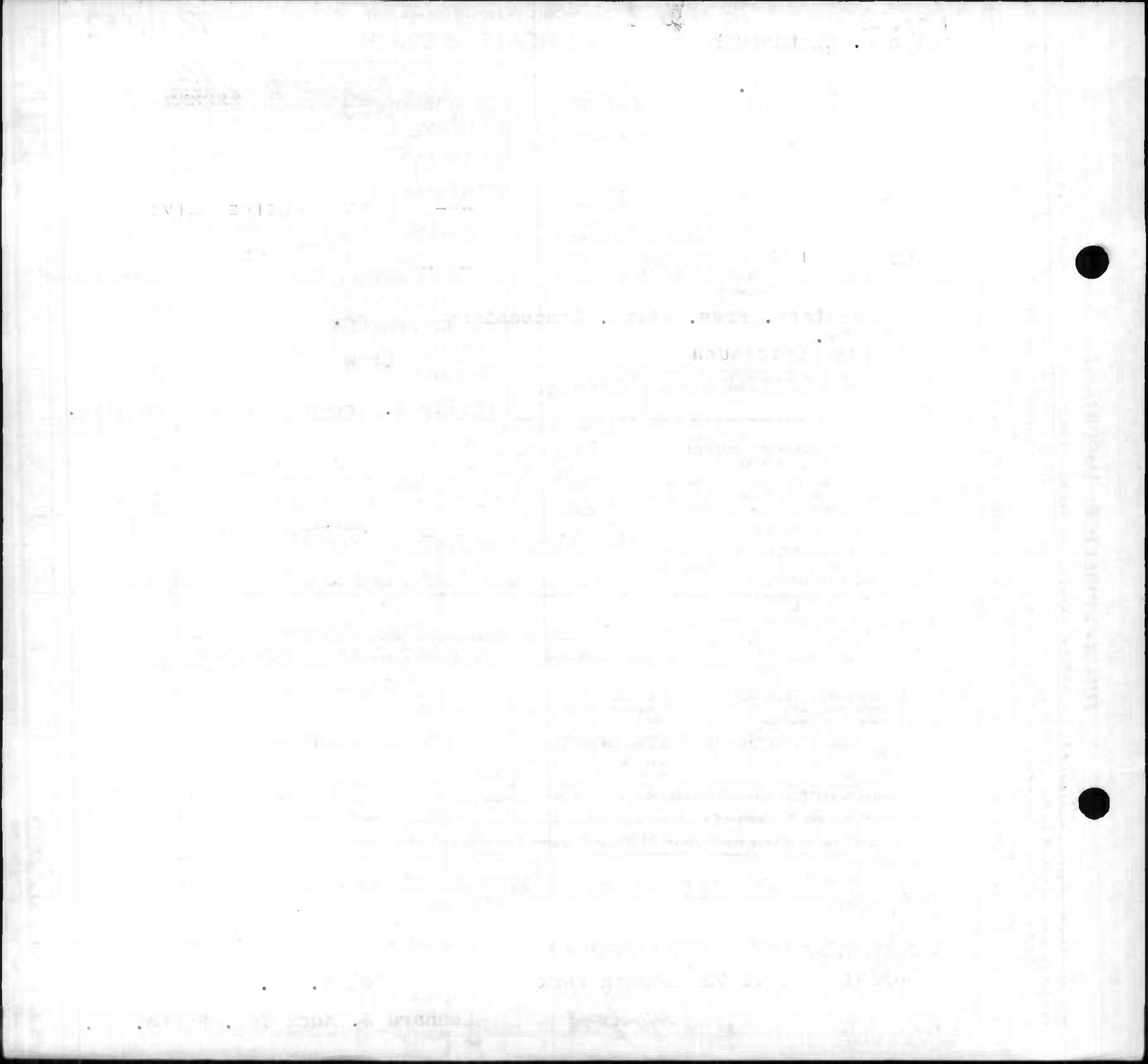
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WALLBURY DRY GOODS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-432 72 07682		72 07682		72 07682	
Ralph J. Klotzbaugh		BIRTH NO.		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		1972	
RALPH J. KLOTZBAUGH		August 9, 1972		8:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived; if institution, residence before admission)		2731	
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND		B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 75++ 3411 PARKSIDE DRIVE			
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2-24-98		9. AGE (In years last birthday) 74		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Candy Manufact. Pres. Balto. Concessions		PA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE KLOTZBAUGH		14. MOTHER'S MAIDEN NAME ELLA Crow			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Philip W. Green 602 Eastern Blvd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH RESPIRATORY AND CARDIAC ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 1) Congestive heart failure, 2) Renal failure (B) DUE TO, OR AS A CONSEQUENCE OF: (C) 2 myocardial infarctions, Assoc Pneumococcal pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes 16 mo. 2) 3 mo 1 yr. 3 hr	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 2, 1972 to August 9, 1972 that (I) (we) last saw the deceased alive on August 9, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John B. Welch M.D. Ph.D. DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/9/72	
23C. PHYSICIAN'S NAME (Type) JOHN B. WELCH M.D. Ph.D. DEGREE		23D. ADDRESS Johns Hopkins Hospital Baltimore, Md.			
24A. BURIAL CREMATION, 24B. DATE Burial 8/12/72		24C. NAME OF CEMETERY OR CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Sidney Johnston		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07683	
L-200 72 07683				STATE OF MARYLAND - DHMH	
BIRTH NO.		72 07683		72 07683	
1. NAME OF DECEASED (Type or Print) LEWIS, WILLIAM S., SR.		2. DATE AND HOUR OF DEATH 8-11-72 8:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 37 MERCY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2664			
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 10, 1892		9. AGE (In years last birthday) 80		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Davis Chemical Co		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William S. Lewis		14. MOTHER'S MAIDEN NAME Sally (Unknown)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-07-7557		17. INFORMANT ADDRESS Mrs. Ethel G. Kessler 5502 Woodmont Ave. #39	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.91		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction, recurrent		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ASCHD & recent INFARCTION		10 days	
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II		Chronic Obstructive Lung Disease		years.	
19A. DATE OF OPERATION 8/11/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Philip H. Moore MD		23B. DATE SIGNED 8/11/72		23C. PHYSICIAN'S NAME (Type) Philip H. Moore MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/72		24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery	
24D. LOCATION Baltimore Maryland		24E. NAME OF REGISTRAR Leonard J. Ruck Inc.		24F. FUNERAL DIRECTOR ADDRESS 5305 Harford Rd. 21214	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Leonard J. Ruck Inc.		25C. FUNERAL DIRECTOR ADDRESS 5305 Harford Rd. 21214	

Feb. 11, 1945

Dear Sir:

Enclosed please find

check for \$100.00

Yours very truly,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-260		72 07684		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07684	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Baker, Sylvia Catherine		2. DATE AND HOUR OF DEATH 8/7/72 6:25 P.M.		STATE OF MARYLAND-DHMH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD U.S. Public Health Service Hospital Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pennsylvania B. COUNTY V 35 C. CITY OR TOWN New Oxford D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Route 1			
5. SEX female	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/3/47	9. AGE (In years last birthday) 24	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilbur L. Nett				14. MOTHER'S MAIDEN NAME Catherine Daugherty			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 180-38-9557		17. INFORMANT Patient		ADDRESS	
18. 201X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Hodgkin's Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION None 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-5 months			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 8/2/72 19 to 8/7/72 19, that (we) last saw the deceased alive on 8/7/72 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE Paul Chang, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/7/72	
23C. PHYSICIAN'S NAME (Type) Paul Chang, M.D.		23D. ADDRESS 3100 Wyman Park Dr.; Baltimore					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/11/1972		24C. NAME OF CEMETERY or CREMATORY National Cemetery		24D. LOCATION (City, town, or county) (State) Gettysburg, Adams Co. Pa.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Sidney L. Houston		25C. FUNERAL DIRECTOR Clarence E. Wilson, Emmitsburg, Md.		ADDRESS	

1870

THE NATIONAL ANTHROPOLOGICAL ARCHIVES

SMITHSONIAN INSTITUTION

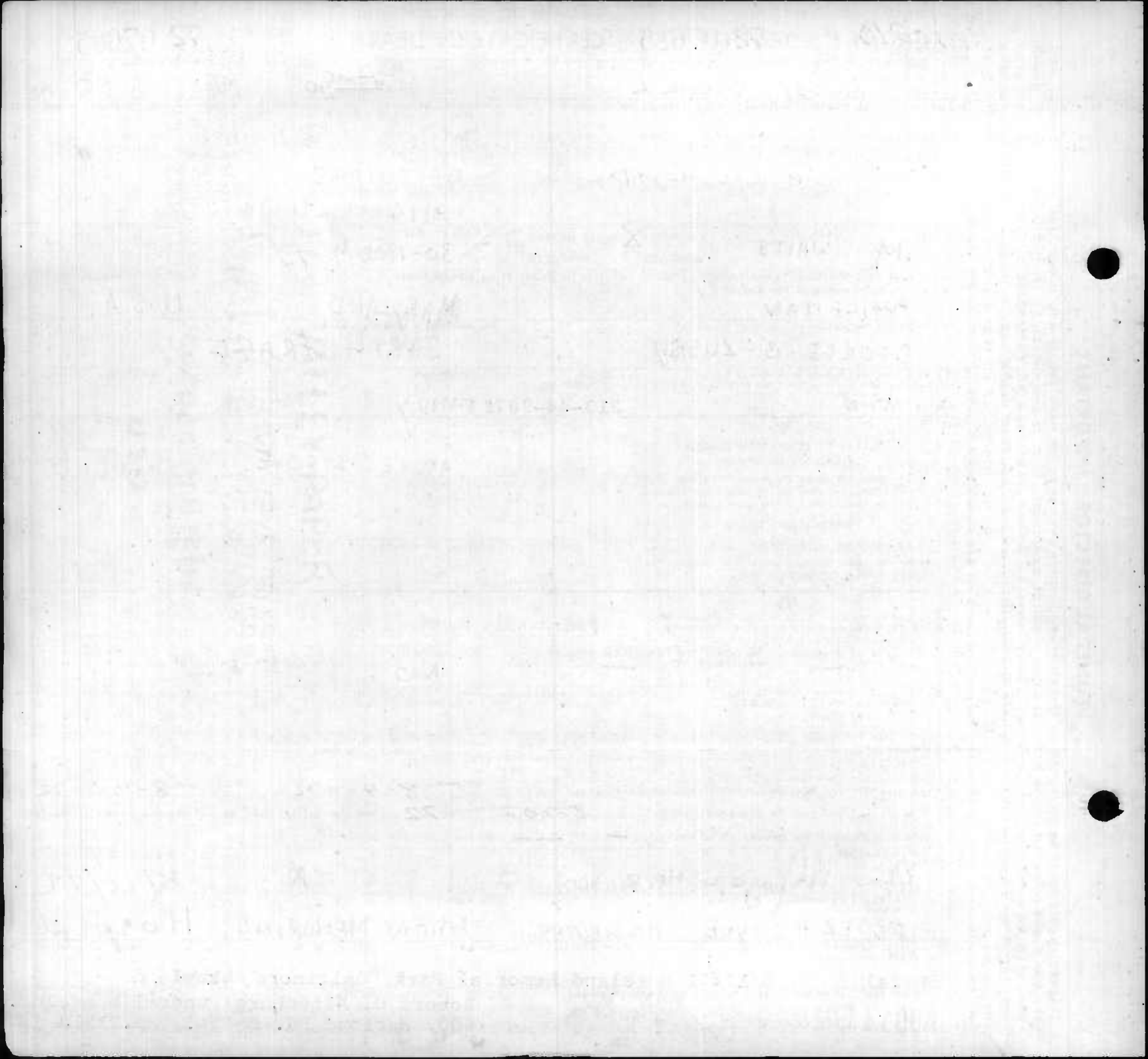
WASHINGTON, D.C.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
L-218		72 07685		72 07685
BIRTH NO.		STATE OF MARYLAND - DEPT		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
LUSBY, OSCAR L		1972 6.30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
44		E. STREET AND NUMBER 3114 NORTHWAY DR. 2735		
5. SEX M	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-30-1900	9. AGE (In years last birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICEMAN		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GEORGE B. LUSBY		14. MOTHER'S MAIDEN NAME SARAH PRAGG		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 213-44-9872		17. INFORMANT FAMILY
18. 436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ACUTE STROKE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). PERNICIOUS ANAEMIA				
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (N) (this hospital) attended the deceased from 8-4-1972 to 8-10-1972, that (I) (we) last saw the deceased alive on 8-10-1972 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Peter H. Joyce M.B. B.A. D.O.		23B. DATE SIGNED 8/10/72		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) PETER H JOYCE M.B. B.A. D.O.		23D. ADDRESS UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/72		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		
25B. NAME OF REGISTRAR Sidney Winston		25C. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home, Inc.		
25D. ADDRESS 6009 Harford Rd. Balto., Md. 21214				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-622		72 07686		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07686	
BIRTH NO.		NAME OF DECEASED		DATE AND HOUR OF DEATH		STATE OF MARYLAND-DHMH	
(Type or Print)		LURAKIS, MARGARET CATHERINE		8/7/72 3:25PM		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE B. COUNTY			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				637 S. Wicohan Rd 2531			
Johns Hopkins Hospital				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
33				Baltimore, Md		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER							
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
♀	CAU.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-14-28	44			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Teacher				Baltimore City		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Windfohr, Henry				Adeline LeFevre			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				214-26-0357		Henry H. Windfohr Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Respiratory arrest 2 w/o			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
				Meningeal Cerebral Edema			
				(B) Ischemic damage			
				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				5			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
8/11/72		Meningeal		Yes		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
NO							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7/20 19 72 to 8/7 19 72 that (I) (we) last saw the deceased alive on 8/7 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Clyde C. Leibrock M.D.				8/7/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
CLYDE C. LEIBROCK M.D.				THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Cremation		8/8/72		Security Process, Inc. Crematorium		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 14 1972		Sidney H. Weston		Edw. S. MacNabb Sons, Inc.		301 Frederick Rd. Catonsville, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		72 07687		BALTIMORE CITY HEALTH DEPARTMENT		72 07687	
1. NAME OF DECEASED (Type or Print)		John RUFF		REG. NO.		STATE OF MARYLAND-DHMH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		2. DATE AND HOUR OF DEATH		9 Aug 72 1 30 A.M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE BALTO, MD		B. COUNTY		1902	
BALTIMORE CITY HOSPITALS 4940 Eastern Ave. Balto. Md. 21224		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1302 W HOLLINS ST. 21223	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Male	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 12, 1907	64	Seaman	U.S., Md.	U-S
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
				FREDERICK RUFF		HADDIE Hattie Rollins	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No?		216-03-7042		BCH: RECORDS		4940 Eastern Avenue Baltimore, Maryland 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Undiff. Tumor compressing spinal cord T 7-8		2 + months			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
April 1972		Compression spinal cord		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from April 23 1972 to 9 Aug 72 1972 that (I) (we) last saw the deceased alive on 8 Aug 72 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Edmunds Beacham MD		9 Aug 72		F. G. BEACHAM M.D.		4940 Eastern Avenue, Baltimore, Maryland BALTO CITY HOSPS. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/12/72		Salem Lutheran Church		Catonsville, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 14 1972		L. J. J. J. J.		Edw. S. MacNabb Sons, Inc.		301 Frederick Rd. Catonsville, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				STATE OF MARYLAND - DHMH	
W-414		72 07688		72 07688	
1. NAME OF DECEASED (Type or Print) <u>Rachael R. Wolfel</u>			2. DATE AND HOUR OF DEATH <u>August 11, 1972</u> <u>2:50</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> <u>5300</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Md. General Hospital</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <u>3508 Milford Mill Rd. 21207</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/22/93</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months: Days: Hours: Mln.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hancock, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Charles Henry</u>		14. MOTHER'S MAIDEN NAME <u>Mary (Michael)</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>21C-03-0109</u>		17. INFORMANT <u>3538 Milford Mill Road</u> ADDRESS <u>D Mr. Walter A. Wolfel, Jr. Balto., Md. 21207</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>410.91</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute myocardial infarction 1 hr.</u> <u>+ pulm. edema.</u>					
(B) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <u>Aortic stenosis</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Aortic Stenosis</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>August 11 1972</u> to <u>August 11 1972</u> that (1) (we) lost saw the deceased alive on <u>August 11 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James H Biddison, M.D.</u>				23B. DATE SIGNED <u>August 11, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>James H Biddison, M.D.</u>				23D. ADDRESS <u>Md. General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/14/1972</u>		24C. NAME of CEMETERY or CREMATORY <u>ST. THOMAS EPISCOPAL CH. CEMET. HANCOCK WASHINGTON CO., MD.</u>	
24D. LOCATION (City, town, or county) (State) <u>21133</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 14 1972</u>			
25B. NAME OF REGISTRAR <u>Sidney J. Hooton</u>		25C. FUNERAL DIRECTOR <u>8728 Liberty Road</u> ADDRESS <u>Loring Byers Funeral Directors, P. A.</u>			

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FUNERAL DIRECTOR: IMPORTANT

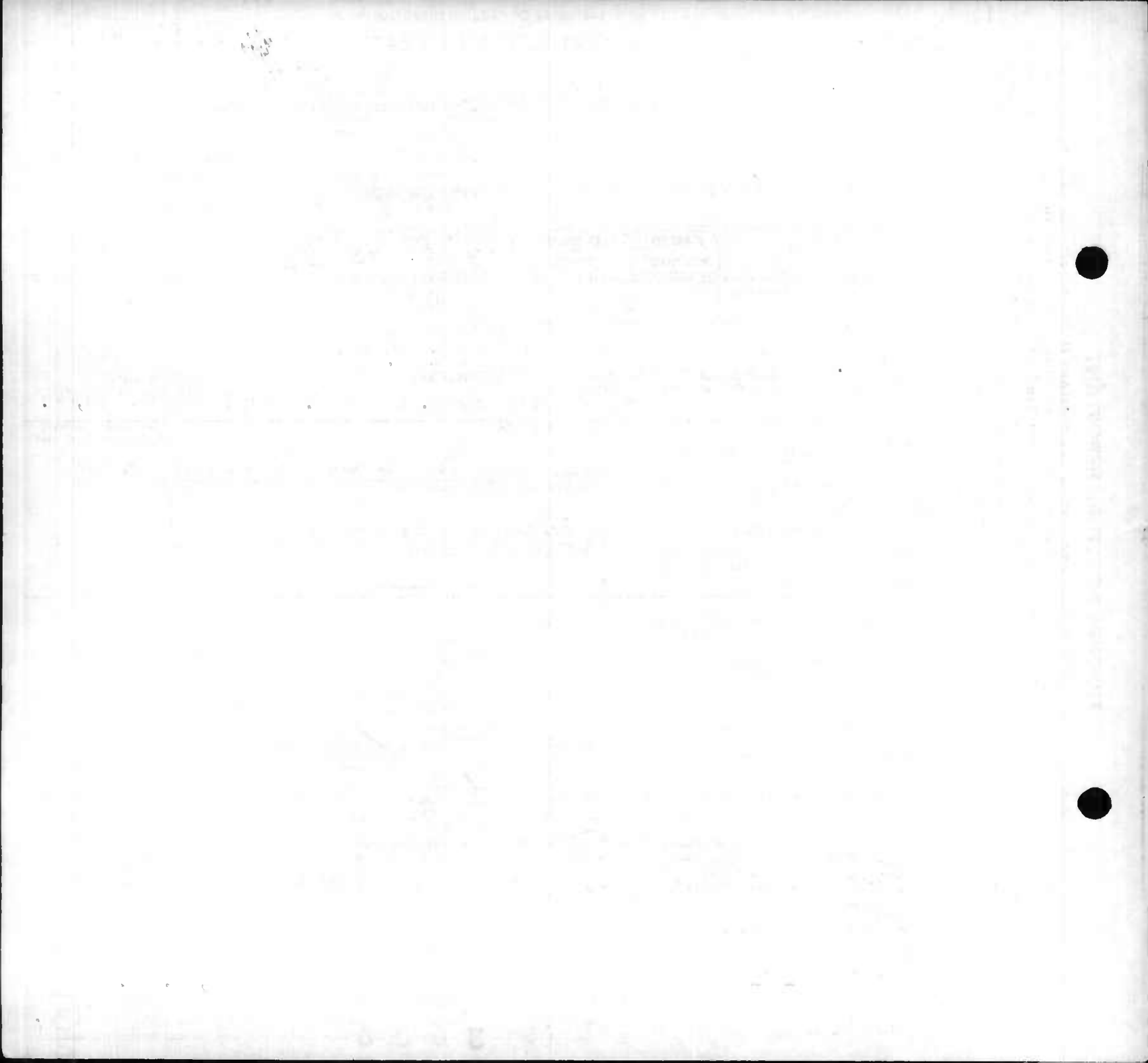
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07689
BIRTH NO. 72 07689		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Pearce, Mildred M</u>		2. DATE AND HOUR OF DEATH <u>Aug. 11 / 72</u> <u>5:30</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>The Union Memorial Hosp</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> 8. COUNTY <u>1348</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Union Memorial Hosp</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>06-22-07</u> 9. AGE (In years last birthday) <u>65</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>John S. Ince</u>		14. MOTHER'S MAIDEN NAME <u>Laura Colter</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-28-7747</u>		17. INFORMANT <u>Naomi Pearce</u>
18. <u>412.3 K-250.9</u>		CAUSE OF DEATH <u>Acute Pulmonary edema</u> <u>Congestive heart failure</u>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>II</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Pulmonary edema</u> (B) <u>Chronic heart disease</u> (C) <u>II</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>II</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		
19A. DATE OF OPERATION <u>2</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 2</u> 19 <u>72</u> to <u>Aug 11</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>Aug 11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Chung-Hsien Yu</u>		23B. DATE SIGNED <u>Aug 11, 72</u>		23C. PHYSICIAN'S NAME (Type) <u>CHUNG-HSIEN YU</u>
23D. ADDRESS <u>The Union Memorial Hosp</u>		23E. DATE SIGNED <u>Aug 11, 72</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/14/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Saters Baptist Church Cem.</u>
24D. LOCATION <u>Baltimore Co., Md.</u>		24E. LOCATION (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 14 1972</u>		25B. NAME OF REGISTRAR <u>Sidney J. Gordon</u>		25C. FUNERAL DIRECTOR <u>A. Alan Seitz, Jr.</u>
25D. ADDRESS <u>3818 Roland Ave.</u>		25E. ADDRESS		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

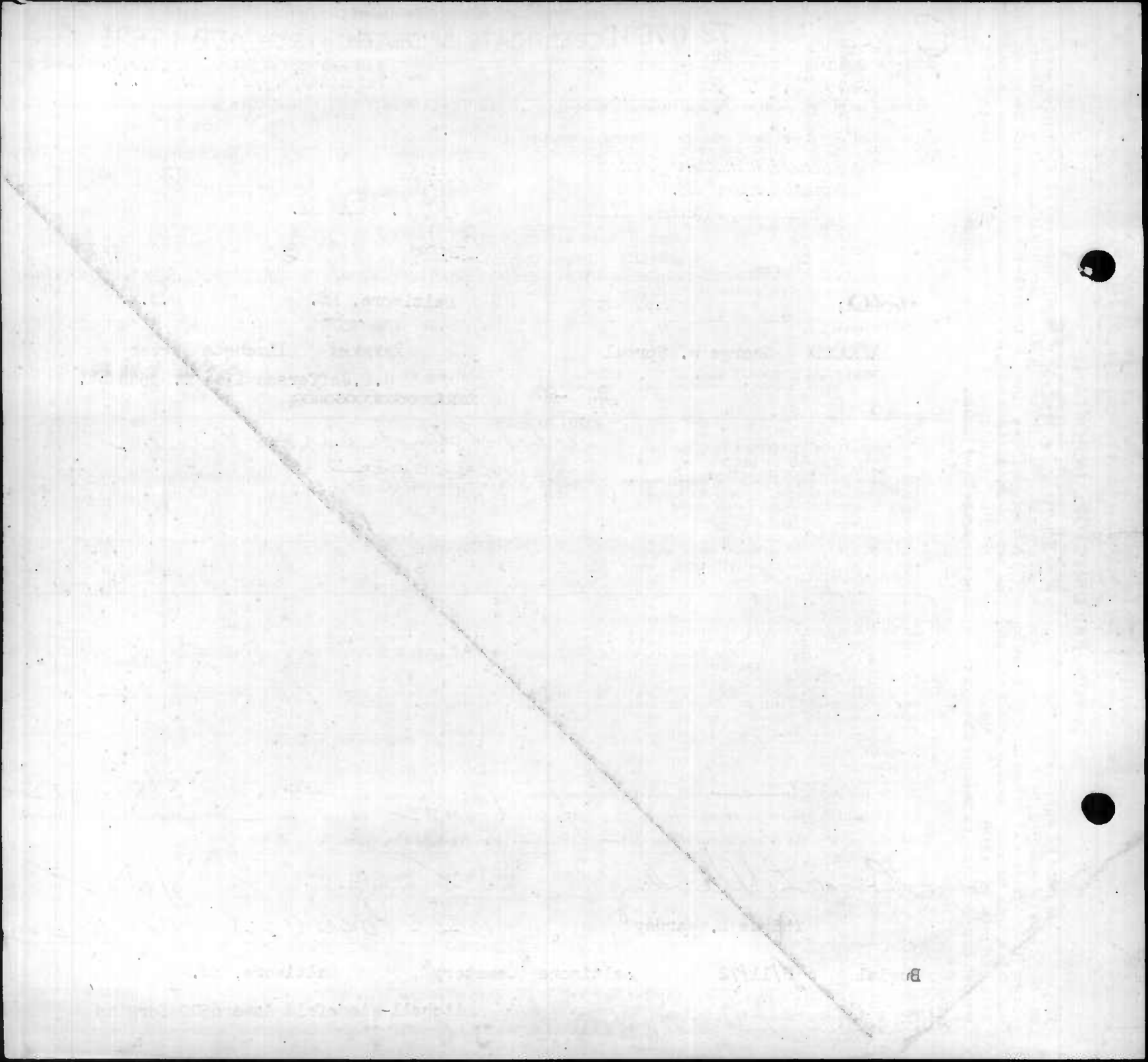
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07690
72 07690				CERTIFICATE OF DEATH
BIRTH NO. <u>D-120</u>		1. NAME OF DECEASED (Type or Print) <u>CATHERINE F. DEBUS</u>		
2. DATE AND HOUR OF DEATH <u>10 AUG 72</u> <u>11 15</u> P.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL HOSP</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>CHARLES</u>		C. CITY OR TOWN <u>HAMPSTEAD</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>RTE 1 Box 145-A</u>		5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <u>3-24-30</u>		9. AGE (in years last birthday) <u>42</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Louis M. Beall</u>		
14. MOTHER'S MAIDEN NAME <u>Tessie V. Bettel</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>216-24-1932</u>		17. INFORMANT <u>John C. De Bus Rt. 1 Box 158K Hampstead, Md.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>202.21</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>PULMONARY INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>METASTATIC LYMPHOMA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>NONE</u>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____
22. I certify that (I) (this hospital) attended the deceased from <u>3 AUG 19 72</u> to <u>10 AUG 19 72</u> that (I) (we) last saw the deceased alive on <u>10 AUG 19 72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Edmund C Tortolani, MD</u>		23B. DATE SIGNED <u>10 Aug 72</u>		23C. PHYSICIAN'S NAME (Type) <u>EDMUND C TORTOLANI, MD</u>
23D. ADDRESS <u>MG-H</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		
24B. DATE <u>8-14-1972</u>		24C. NAME of CEMETERY or CREMATORY <u>Woodlawn Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn Balto, Co. Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 14 1972</u>		25B. NAME OF REGISTRAR <u>Adm. J. H. H. H.</u>		25C. FUNERAL DIRECTOR <u>John T. Stansbury 6411 Windsor Mill Rd.</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72-07691
72 07691 CERTIFICATE OF DEATH				STATE OF MARYLAND - DHMH
BIRTH NO. S-432		1. NAME OF DECEASED (Type or Print) Goldie M. Slitzer		
2. DATE AND HOUR OF DEATH August 8, 1972 2:59 P.M.		M. 902		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Hamilton Nursing Center 6040 Harford Rd. Baltimore, Maryland 21214		A. STATE MD. B. COUNTY 902		
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 1509 E. 35th St.				
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-3-1889	9. AGE (In years last birthday) 83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10B. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME XXXXXXXXX George W. Sproul		14. MOTHER'S MAIDEN NAME XXXXXXXXX Elizabeth Garver		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 4977-50		17. INFORMANT R.T. Jefferson 1509 E. 35th St.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 412.4 I Arteriosclerotic Cardio Vascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardio Vascular Disease		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1949 to 8/8 19 72 , that (I) (we) last saw the deceased alive on 8/1 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Thomas L. Wardey		23B. DATE SIGNED 8/8/72		
23C. PHYSICIAN'S NAME (Type) Thomas L. Wardey		23D. ADDRESS 6505 York Road Baltimore, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/11/72		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Sidney S. Wiedefeld		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home
25D. ADDRESS 6500 York Rd				

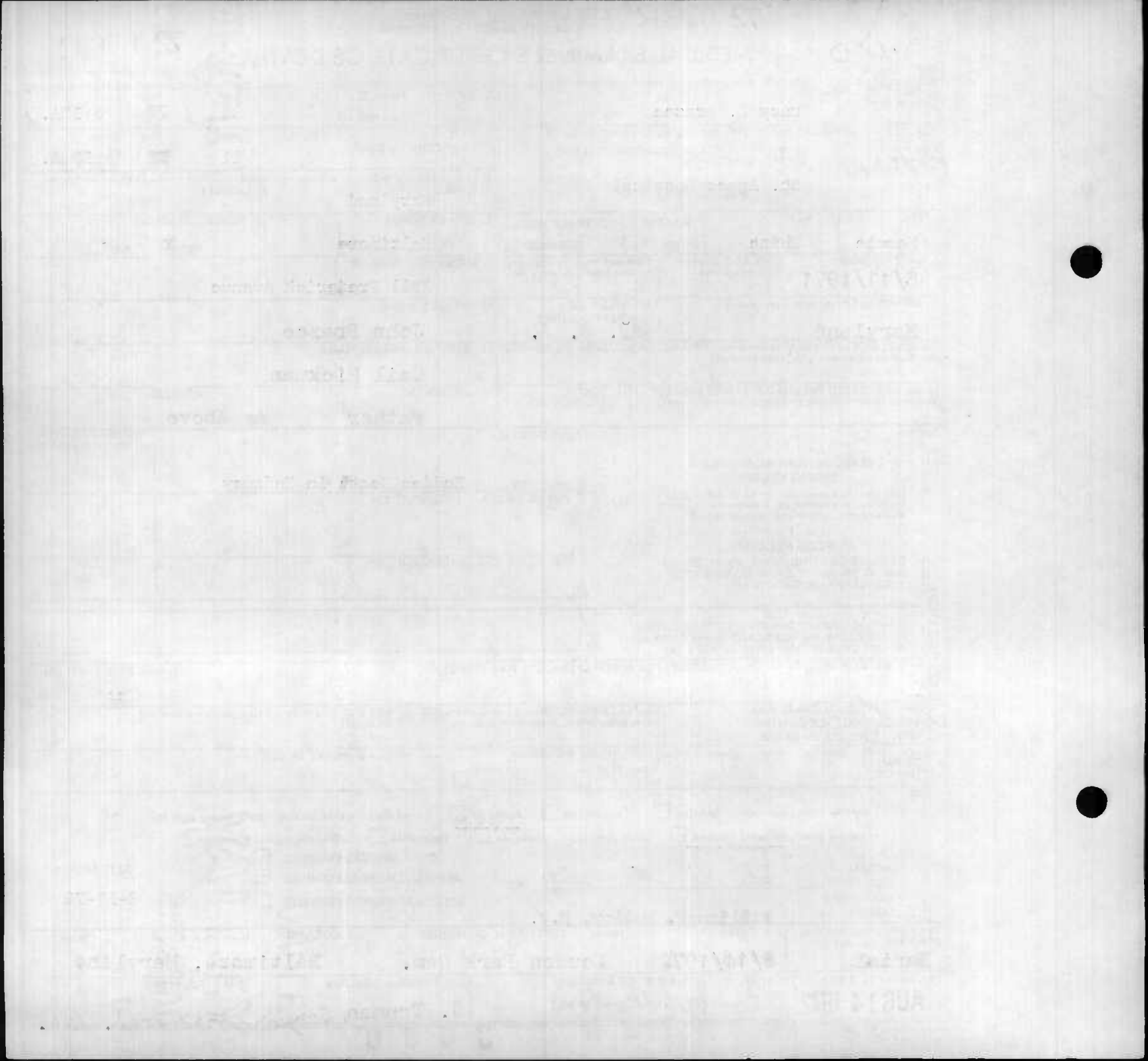


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07692
STATE OF MARYLAND - DHMH

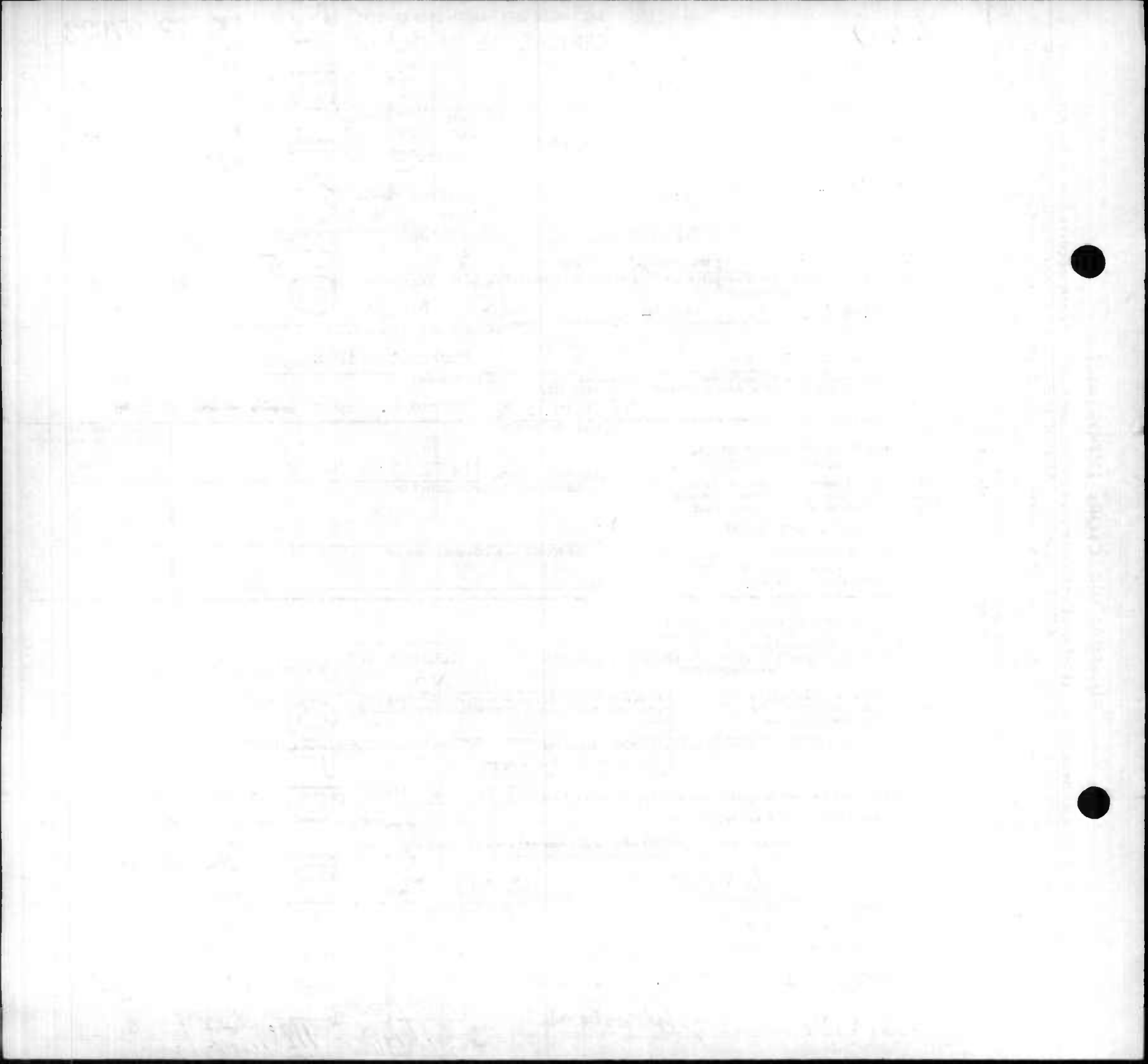
BIRTH NO. 71-19329

1. NAME OF DECEASED (Type or Print) Tracy L. Brazee		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 8 Day 11 Year 72 Hour 6:30A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month 8 Day 11 Year 72 Hour 6:30 A. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 11/13/71 8/11/1971		10. AGE (in years last birthday) 8	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Gail Hickman		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Father	
19. 795X1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-11-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/1972	
24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Lidney Houston	
25C. FUNERAL DIRECTOR G. Truman Schweb		ADDRESS 3512 Fred. Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

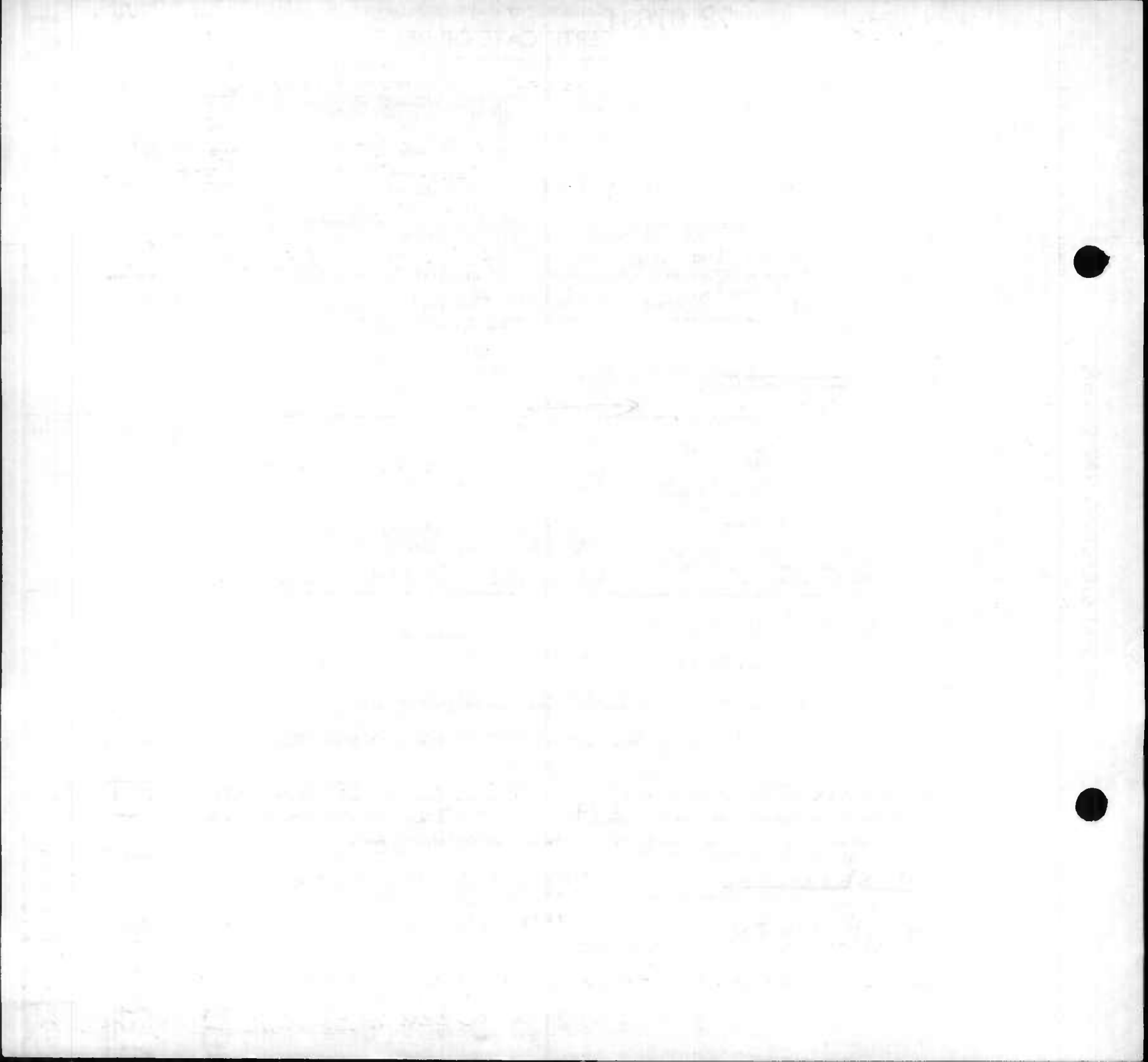
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07693	
72 07693				STATE OF MARYLAND-DHMH	
BIRTH NO. P-160		72 07693		6:30 P.M.	
1. NAME OF DECEASED (Type or Print) ESTHER C. PIPER		2. DATE AND HOUR OF DEATH 8/10/72			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL		A. STATE MD		B. COUNTY BALTO.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
34		E. STREET AND NUMBER 1404 UNION AVE			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/10/87	9. AGE (in years last birthday) 85	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Herbert Crabbe		14. MOTHER'S MAIDEN NAME Margaret Haines			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-56.1433 JT		17. INFORMANT Monroe H. Piper	
		ADDRESS 1404 Union Avenue			
18. 444.21		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE INTESTINAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) ---		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 8:10 72 1am 19 72 to 8 10 72 6pm 19 72 and that (I) (we) last saw the deceased alive on at death 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sam Kerr M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8 10 72	
23C. PHYSICIAN'S NAME (Type) Sam C. Kerr M.D.		23D. ADDRESS BON SECOURS HOSPITAL BALTO.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 14 Aug 72		24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park	
24D. LOCATION (City, town, or county) (State) Taylor Ave, Balto Md 21234					
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Sidney Johnston		25C. FUNERAL DIRECTOR Burgee Funeral Home Baltimore Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

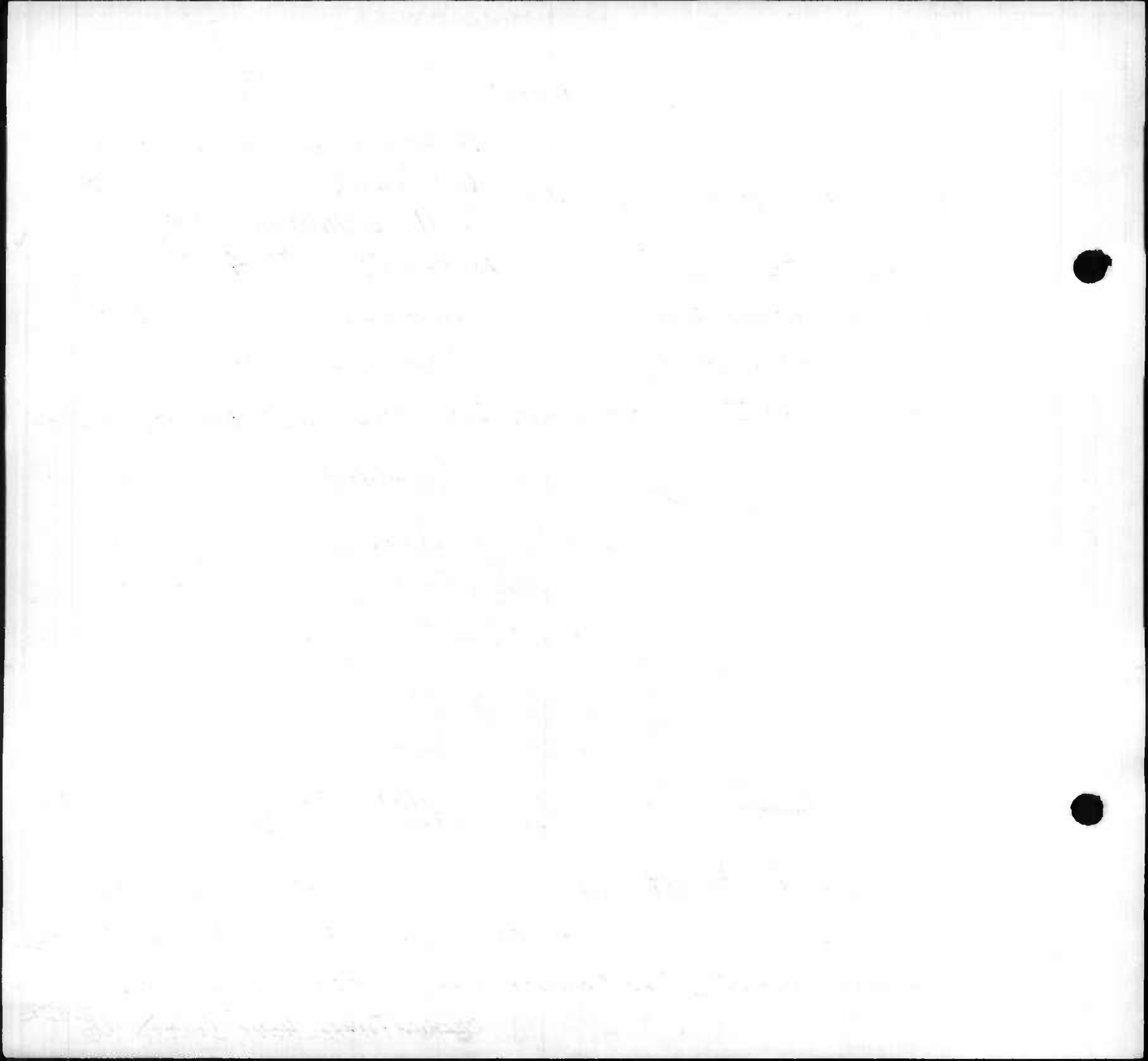
BALTIMORE CITY HEALTH DEPARTMENT		72 07694		72 07694	
C-636		72 07694		72 07694	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CARTER, GEORGE Wesley		2. DATE AND HOUR OF DEATH 8/10/72 1 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO		5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 44		E. STREET AND NUMBER 910 Northpoint Road.	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 June 11	9. AGE (In years last birthday) 61	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired.		10B. KIND OF BUSINESS OR INDUSTRY General Motors		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 213-10-4797		16. SOCIAL SECURITY NO. 213-10-4797		17. INFORMANT CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 571.01		CAUSE OF DEATH GI		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Circulatory collapse.			
		(B) Liver Cirrhosis - Alcoholic DUE TO, OR AS A CONSEQUENCE OF:			
		(C) Cerebro-Vascular accident DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 6 19 72 to 8/20 19 72 that (I) (we) last saw the deceased alive on 8/19 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. Shocair				23B. DATE SIGNED 8/10/72	
23C. PHYSICIAN'S NAME (Type) M. SHOCAIR				23D. ADDRESS Union Memorial Hospital Baltimore Md	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11 AUG 72		24C. NAME of CEMETERY or CREMATORY OAK LAWN CEMETERY	
24D. LOCATION BALTIMORE MD 21224		24E. CITY, TOWN, OR COUNTY BALTIMORE MD		24F. STATE MD	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Shirley Thompson		25C. FUNERAL DIRECTOR George Funeral Home, Baltimore	
25D. ADDRESS 2140					



FUNERAL DIRECTOR: IMPORTANT

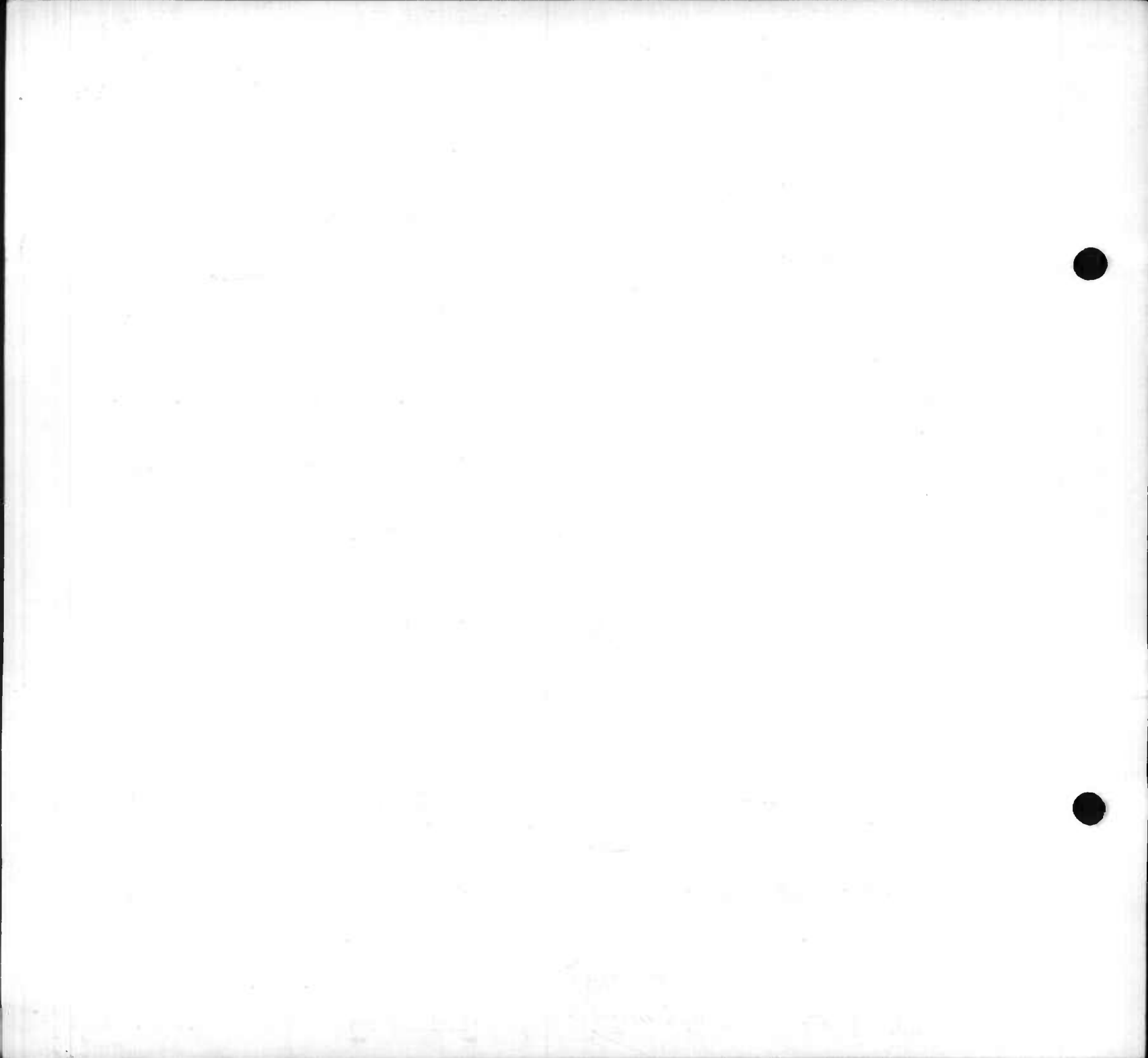
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 07695	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>EARL D. REID</u>		2. DATE AND HOUR OF DEATH <u>8/8/72 4:15P</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE JOHNS HOPKINS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>DUNDALK</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>7011 DUNMAN WAY 5300</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-97</u>		9. AGE On years (last birthday) <u>74</u> If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPEN HEARTH FOREMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>(UNOBTAINABLE)</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>213-07-8652</u>		17. INFORMANT <u>IVY Y. REID, 7011 DUNMAN WAY 21222</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>↓ cough reflex, candida</u> DUE TO, OR AS A CONSEQUENCE OF: <u>sepsis</u> (C) <u>massive CVA & cerebral dysfunction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 weeks</u> <u>1 mo.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>gangrene of foot, myocardial infarction</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/27</u> <u>1972</u> to <u>8/8</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>8/8</u> <u>1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Craig R. Smith MD</u>		23B. DATE SIGNED <u>8/8/72</u>		23C. PHYSICIAN'S NAME (Type) <u>CRAIG R. SMITH M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12 AUG 72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD. 21224</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 14 1972</u>			
25B. NAME OF REGISTRAR <u>Edna J. Smith</u>		25C. FUNERAL DIRECTOR <u>CELESTINE FUNERAL HOME, DUNDALK, MD</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>S-530 72 07696 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 07696</p>	
<p>BIRTH NO. 72 07696</p>		<p>1. NAME OF DECEASED (Type or Print) Barbara Schmidt</p>	
<p>2. DATE AND HOUR OF DEATH 9 August 1972</p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>	
<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Md. B. COUNTY 2632</p>		<p>5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>House in the Pines...Belaire</p>	
<p>6. CITY OR TOWN Baltimore 21213</p>		<p>7. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>8. STREET AND NUMBER 4608 Kavon Ave.</p>			
<p>9. SEX Female</p>	<p>10. RACE Caucasian</p>	<p>11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>12. DATE OF BIRTH 2 Feb 1886</p>
<p>13. AGE (In years last birthday) 86</p>		<p>14. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>	
<p>15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) hswf.</p>		<p>16. KIND OF BUSINESS OR INDUSTRY</p>	
<p>17. BIRTHPLACE (State or foreign country) Maryland</p>		<p>18. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>19. FATHER'S NAME Henry Grauer</p>		<p>20. MOTHER'S MAIDEN NAME unobtainable</p>	
<p>21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no</p>		<p>22. SOCIAL SECURITY NO.</p>	
<p>23. INFORMANT Herbert L. Grymes, Esq. Col. Sq. Bldg. 21201</p>		<p>24. ADDRESS</p>	
<p>25. CAUSE OF DEATH</p> <p>18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE Antisepsis of Hand Drain DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) Generalized Antisepsis DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>			
<p>26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> <p>Resumes Epistaxis Chronic Brain Spasms</p>			
<p>27. DATE OF OPERATION</p>		<p>28. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)</p>		<p>30. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>32. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>33. TIME OF INJURY (Month (Day) (Year) (Hour) (Approx.)</p>		<p>34. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>35. HOW DID INJURY OCCUR?</p>			
<p>36. I certify that (I) (this hospital) attended the deceased from 12/16/1970 to 8/9/1972 that (I) (we) lost saw the deceased alive on 8/9/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</p>			
<p>37. SIGNATURE Albert B. Bradley</p>		<p>38. DATE SIGNED 8/11/72</p>	
<p>39. PHYSICIAN'S NAME (Type) A.B. Bradley, MD</p>		<p>40. ADDRESS 4900 Belair Rd. 21206</p>	
<p>41. BURIAL CREMATION, REMOVAL (Specify) burial</p>		<p>42. DATE 12 Aug 72</p>	
<p>43. NAME OF CEMETERY or CREMATORY Jerusalem Cemetery</p>		<p>44. LOCATION (City, town, or county) (State) Balto., Md. 21206</p>	
<p>45. DATE REC'D BY HEALTH DEPT. AUG 14 1972</p>		<p>46. NAME OF REGISTRAR Andrew W. Houston</p>	
<p>47. FUNERAL DIRECTOR Ulrich Funeral Home, Balto., Md. 21206</p>		<p>48. ADDRESS</p>	



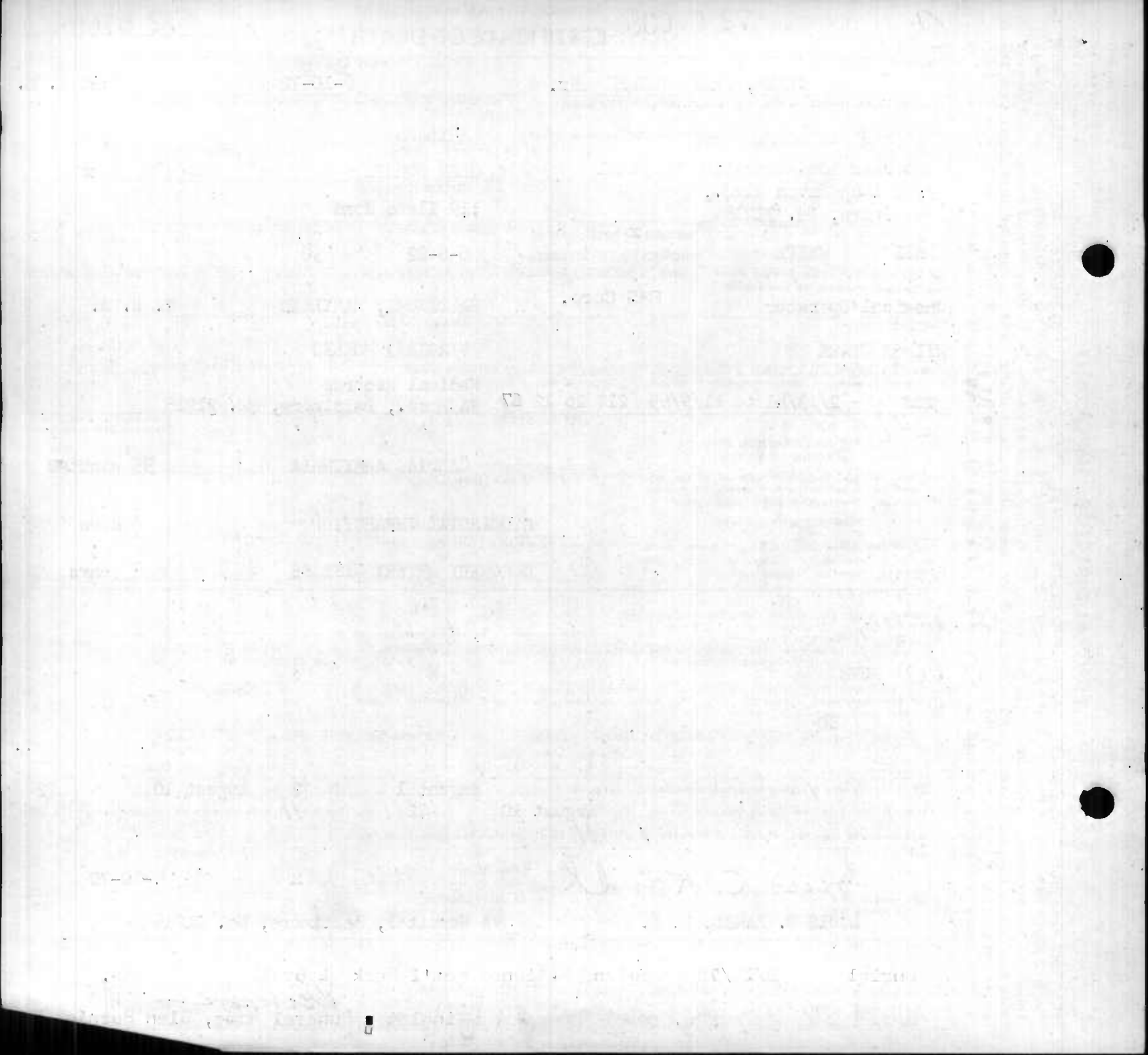
BIRTH NO.		STATE OF MARYLAND - DEPT. OF HEALTH		REG. NO.	
S-160		72 07697		72 07697	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD	
CLARENCE W. Schaefer		Known <input checked="" type="checkbox"/> Month Day Year August 10, 1972		Estimated <input type="checkbox"/> August 10, 1972 3:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)		6. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home & Hospital		A. STATE Maryland		B. COUNTY Anne Arundel	
6. SEX		7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (in years lost birthday)		11. BIRTHPLACE (State or foreign country)	
Oct. 29, 09		62		Norfolk, Va.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
USA		Clarence W. Schaefer, Sr.		Banking Mgr.	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
Matilda Suffner		No		216/01/0010	
18. INFORMANT		19. CAUSE OF DEATH		20. DATE OF OPERATION	
Mrs. Maud A. Schaefer Wife		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebro-cranial injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		27-9-72	
21. AUTOPSY? (Yes or No)		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		23. TIME OF INJURY (APPROX.)	
Yes		Street (5) Baltimore St. S. of 17th St. Ocean City, Maryland		6-7-72 8:41 P.M.	
24. BURIAL CREMATION, REMOVAL (Specify)		25. NAME OF REGISTRAR		26. FUNERAL DIRECTOR	
Burial		8/14/72		Singleton Funeral Home, Glen Burnie, Md.	
27. DATE REC'D BY HEALTH DEPT.		28. NAME OF REGISTRAR		29. FUNERAL DIRECTOR	
AUG 14 1972		Sidney H. Heston		H. Heston	

8-17-1972 - Letter from the Office of the Chief Medical Examiner, Ronald N. Kornblum, M.D. .
Deputy Chief Medical Examiner. HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07698	
C-462 72 07698				STATE OF MARYLAND - DHMH	
BIRTH NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) CLARK, FRANK JOSEPH Sr.			8-10-72 7:50 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY AA		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218			C. CITY OR TOWN GLEN BURNIE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX MALE 6. RACE WHITE			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-6-22
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemical Operator			10B. KIND OF BUSINESS OR INDUSTRY FMC Corp.		9. AGE (In years last birthday) 50
13. FATHER'S NAME WILBER CLARK			14. MOTHER'S MAIDEN NAME VIRGINIA MORRIS		12. CITIZEN OF WHAT COUNTRY? U. S. A.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 2/13/41 to 11/9/45			16. SOCIAL SECURITY NO. 217 26 12 67		17. INFORMANT Medical Records VA Hosp., Baltimore, Md. 21218
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARRYTHMIA (B) MYOCARDIAL INFARCTION (C) CORONARY ARTERY DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 55 minutes 8 days 8 years
19A. DATE OF OPERATION 0 NONE			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from August 1 19 72 to August 10 19 72 , that (1) (we) last saw the deceased alive on August 10 19 72 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis C. Kandl				23B. DATE SIGNED 8-10-72	
23C. PHYSICIAN'S NAME (Type) LOUIS C. KANDL, M. D.			23D. ADDRESS VA Hospital, Baltimore, Md. 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/72		24C. NAME OF CEMETERY or CREMATORY Maryland National Mem'l Park Laurel Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Sidney H. Foxton		25C. FUNERAL DIRECTOR Singleton Funeral Home, Glen	

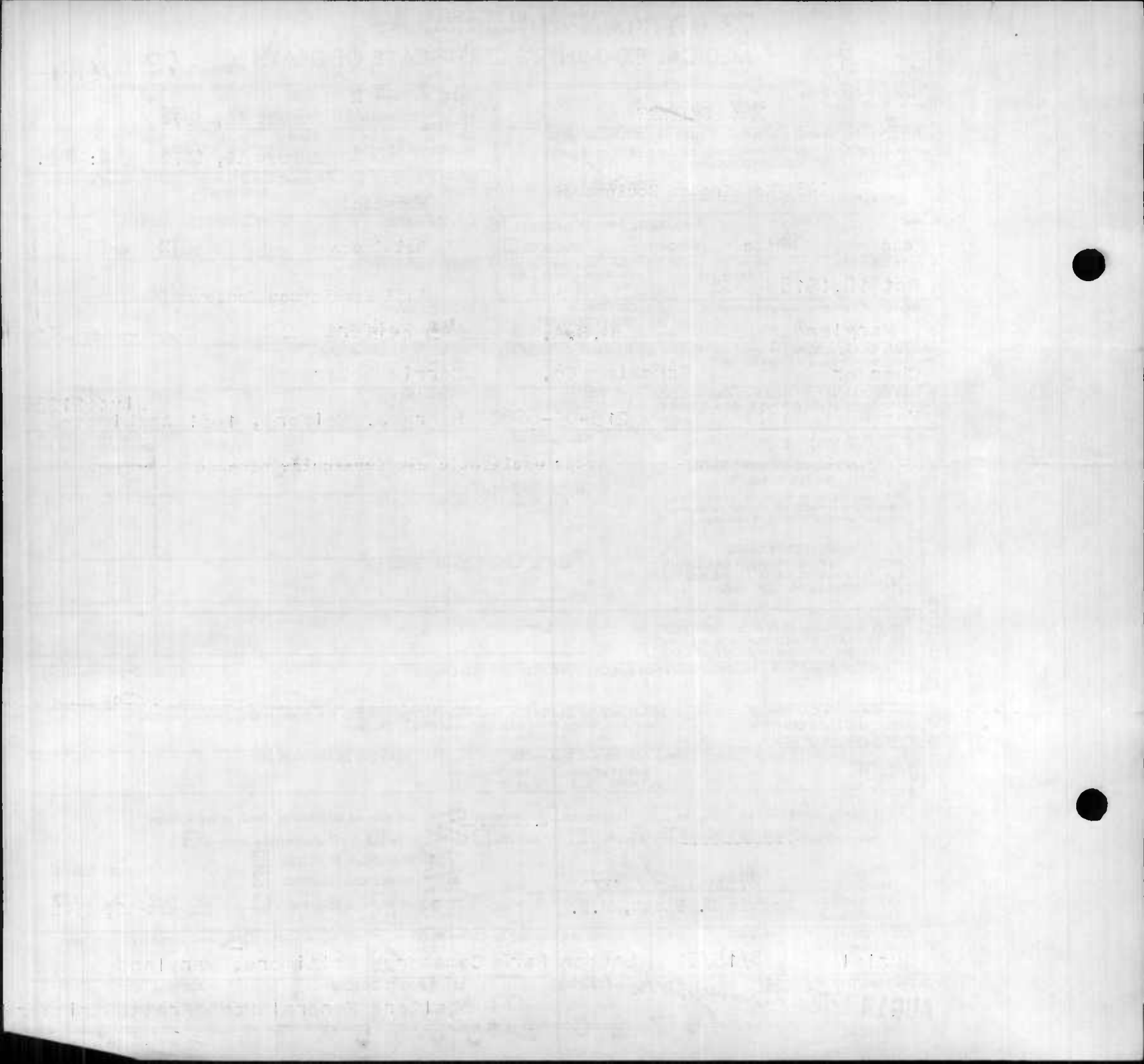


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07689

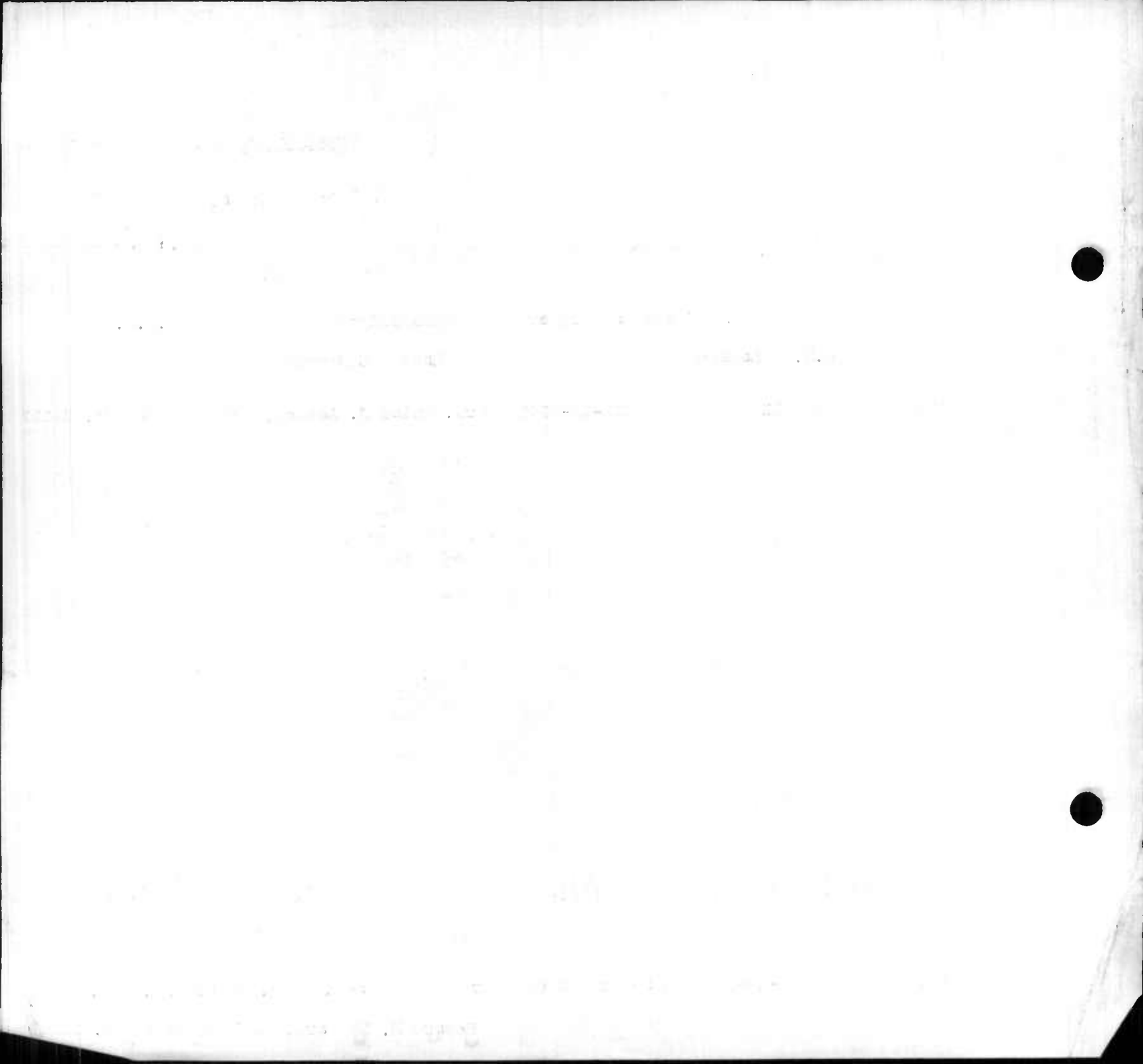
BIRTH NO. S-163

1. NAME OF DECEASED (Type or Print) MAX SEIFERT		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 11, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1451 Washington Boulevard		3. DATE PRONOUNCED DEAD Month Day Year Hour August 11, 1972 4:40 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Oct 18, 1918		10. AGE (In years last birthday) 53	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker		14B. KIND OF BUSINESS OR INDUSTRY Trucking Co.	
15. MOTHER'S MAIDEN NAME Carrie Weber		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II	
17. SOCIAL SECURITY NO. 215-09-8688		18. INFORMANT Henry J. Seifert, 1451 Washington	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 12, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/72	
24C. NAME OF CEMETERY or CREMATORY Loydon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Lindsey H. Pratt	
25C. FUNERAL DIRECTOR Walters Funeral Home Pratt & Stricker		ADDRESS Street	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

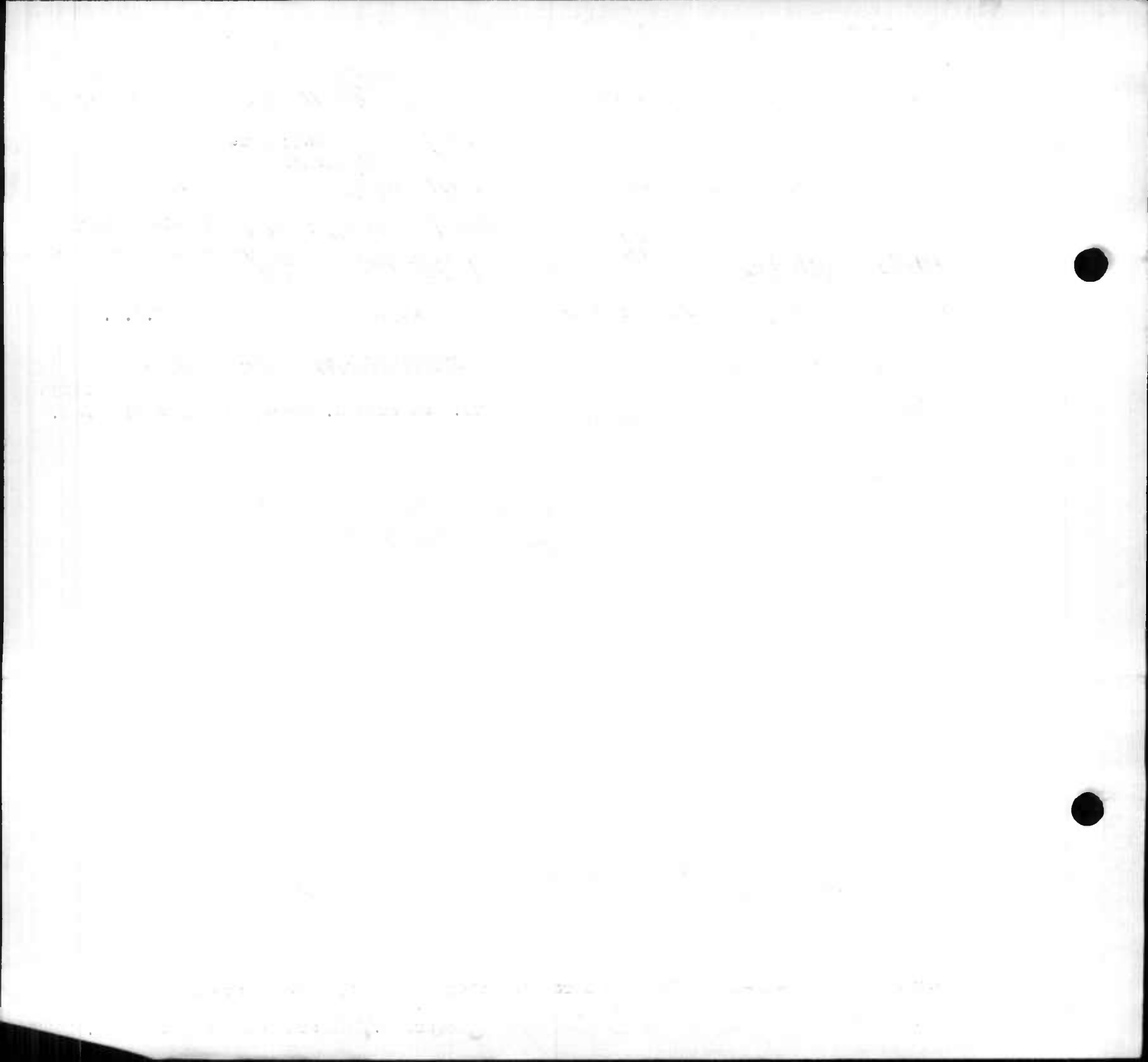
L-250		72 07700		BALTIMORE CITY HEALTH DEPARTMENT		X		72 07700	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		C.		2. DATE AND HOUR OF DEATH		REG. NO.	
		MILTON LAWSON				9 August 1972		P	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				md		Baltimore		HOWARD	
UNIVERSITY OF MARYLAND				C. CITY OR TOWN		D. INSIDE CITY LIMITS?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER		7066 Kit Kat Road		KIT KAT Rd Box 265c	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7-23-11		61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Self Employed				Horse Van Driver		Mississippi		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		ADDRESS			
W.E. Lawson				Kate Clemmons		Mrs. Helen J. Lawson, 7066 Kit Kat Rd. 21227			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			
Yes				W W II		421-16-4792			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE				many yrs	
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:				many yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) lost saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Stanley A. Morrison MD				8/9/72					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
				Univ of Md Hosp					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		8-14-1972		Meadowridge Cemetery		Wash. Blvd. Howard Co., Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
AUG 14 1972		Andrew A. Hubbard		Howard B. Hubbard		4107 Wilkens Ave. 21			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 07701	
D-500 72 07701		STATE OF MARYLAND-DHMH			
BIRTH NO.		2. DATE AND HOUR OF DEATH 8-11-72 8:10 A.M.			
1. NAME OF DECEASED (Type or Print) WILFRED C. Downey		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secours Hospital 34			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Baltimore		5. SEX male 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 11-25-97 9. AGE (In years last birthday) 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police Chief Emer			
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Downey		14. MOTHER'S MAIDEN NAME XXXXXXXXXX MARY BRUNING			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-40-2188		17. INFORMANT ADDRESS 21230 Mrs. Margaret E. Downey, 2831 Maudlin Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular accident Chronic Atherosclerosis (B) PROBABLE CAUSE OF DEATH DUE TO, OR AS A CONSEQUENCE OF: Probable Cerebral Infarction (C) _____			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Howard H. Hubbard</i> MD		23B. DATE SIGNED 8-11-72		23C. PHYSICIAN'S NAME (Type) _____	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-14-1972		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. STATE (State) Maryland		24F. ADDRESS _____	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR <i>Dr. J. H. Hubbard</i>		25C. FUNERAL DIRECTOR <i>Howard H. Hubbard</i>	
VS 150-REV. 1/1/68		ADDRESS 4107 Wilkens Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-160		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07702	
BIRTH NO. 72 07702		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		NEUBAUER, FRANCES KATHERINE		2. DATE AND HOUR OF DEATH AUGUST 09, 1972 9:25 P.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		MARYLAND HOWARD 6300	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN ELKRIDGE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
40 ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE, MARYLAND 21229		E. STREET AND NUMBER 6283 OLD WASHINGTON RD,		21227	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09-04-01	9. AGE (In years last birthday) 70	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE Cook Retired
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM DEMBECK		14. MOTHER'S MAIDEN NAME CATHERINE (AUGUSTINAK)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-20-2159		17. INFORMANT BALTO. MD. 21229 ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CARDIOGENIC SHOCK. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PAPILLARY MUSCLE RUPTURE (B) ACUTE MYOCARDIAL INFARCTION - 11 days (C) ARTERIOSCLEROTIC CARDIO- VASCULAR DISEASE. HYPERTENSION.		19. DATE OF OPERATION 2		20. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 29 1972 to AUGUST 09 1972, that (I) (we) last saw the deceased alive on AUGUST 09 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harjit Singh M.D.		23B. DATE SIGNED 8-10-72		23C. PHYSICIAN'S NAME (Type) HARJIT SINGH M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-14-1972		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Sidney Houston		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	

AUGUST 09, 1937

HEAVY, F. M. S. CATHOLIC

MARYLAND

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ST. ANNE'S HOSPITAL

WILKINS & CATHERINE

BALTIMORE, MARYLAND 21222

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FEMALE WHITE

MARYLAND

HOSPITALITY CO. (BALTIMORE)

CATHERINE (QUESTIONS)

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72 07703

STATE OF MARYLAND - JUNE
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07703

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MORTON A. BARRON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 9, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour August 9, 1972 11:55 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2755	
9. DATE OF BIRTH 1/20/1929		10. AGE (In years lost birthday) 43 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A. X	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISTRIBUTOR		13. FATHER'S NAME SAMUEL BARRON	
14B. KIND OF BUSINESS OR INDUSTRY WALLPAPER		15. MOTHER'S MAIDEN NAME BERTHA BERMAN	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	
18. INFORMANT MRS. INGE BARRON, 2100 W. ROGERS AVE. #21209		ADDRESS	

19. E812.0 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Multiple injuries (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Cross Country Road & South Road	
22D. TIME OF INJURY (APPROX.) 8-9-72 11:40 P. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Driver in auto-auto collision)	

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE: Marvin S. Platt M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 10, 1972		

24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/10/72		24C. NAME of CEMETERY or CREMATORY BETH TFILOH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
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25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Adrian H. Hinton		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07704
BIRTH NO. K-145		72 07704		STATE OF MARYLAND
1. NAME OF DECEASED (Type or Print) NATHAN KAPLAN		2. DATE AND HOUR OF DEATH AUGUST 10, 1972 5³⁰ A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3626 FORDS LANE, APT. C		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2720 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3626 FORDS LANE, APT. C		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/1/1903	9. AGE (In years last birthday) 69 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME DAVID KAPLAN		
14. MOTHER'S MAIDEN NAME LENA TUCKER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 217-26-3203		17. INFORMANT MRS. EDITH KAPLAN, 3626 FORDS LANE, APT. C		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: ant & cl cv disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 8 yrs		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) none		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 8/10/72 to 8/10/72 and that (I) (we) last saw the deceased alive on 8/10/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Maurice Fedlman, Jr. DEGREE				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) MAURICE FEDLMAN, JR. DEGREE		23D. ADDRESS 6610 CROSS COUNTRY BLVD.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8/11/72	24C. NAME of CEMETERY or CREMATORY HEBREW YOUNG MEN	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Adolph H. ...		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD ADDRESS

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07705

BIRTH NO. Z-545

1. NAME OF DECEASED (Type or Print) JOSEPH ZIMLIN ZIMLIN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 10, 1972 9:15 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour August 10, 1972 9:15 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH MARCH 15, 1917		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (in years lost birthday) 55		E. STREET AND NUMBER 3113 Shelbourne Road	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DAVID ZIMLIN		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR	
15. MOTHER'S MAIDEN NAME ANNA		16. KIND OF BUSINESS OR INDUSTRY STEEL	
17. SOCIAL SECURITY NO. 213-10-7547		18. INFORMANT ADDRESS MRS. BERNICE ZIMLIN, 3113 SHELBOURNE RD. #21208	
19. E 881 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebro-cranial injuries DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: Electrical injury, left arm		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) factory		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Zimlins Ornamental Iron Corp. 2831	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 8-9-72 1:45 P.		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR? 5225 Fairlawn Ave. Fell from ladder while working on electric motor		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 10, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/11/72	
24C. NAME OF CEMETERY or CREMATORY AITZ CHAIM		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Sidney Kornblum	
25C. FUNERAL DIRECTOR SOL LEVINSOHN & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07706		REG. NO. 72 07706	
BIRTH NO. 5-220				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SYKES, SAMUEL				2. DATE AND HOUR OF DEATH 8-10-72 7:25 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE MARYLAND B. COUNTY 2720			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3803 FORDRICH BO., APT. A			
5. SEX M MALE	6. RACE W WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-21-02	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMPLOYEE		10B. KIND OF BUSINESS OR INDUSTRY SWARTZ CADILLAC CO.		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JACOB SYKES				14. MOTHER'S MAIDEN NAME SARAH SIMONSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. SADIE DONER, 4401 CONSHOHOCKEN AVE. PHILA, PA.			
18. 427.01 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 8-10-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED POCK		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 8-10-72 to 8-10-72 that (1) (we) last saw the deceased alive on 8-10-72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sahachai Mushiabunna				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-10-72	
23C. PHYSICIAN'S NAME (Type) SAHASCHAI MUSHIABHUNNA				23D. ADDRESS SINAI HOSPITAL OF BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/11/72		24C. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO (ARLINGTON)		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Sidney J. Houston		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., #6010 REISTERSTOWN ROAD			

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WATKINS, HARRISON

STATE OF ILL. CO.

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STATE OF ILL. CO.

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WATKINS, HARRISON

WATKINS, HARRISON

STATE OF MARYLAND - DISTRICT OF BALTIMORE CITY HEALTH DEPARTMENT									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
BIRTH NO. 65-30717					REG. NO. 72 07707				
1. NAME OF DECEASED (Type or Print) ELEANOR R. BARRON					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> August 9, 1972				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital (DOA)					3. DATE PRONOUNCED DEAD Month Day Year Hour August 9, 1972 11:55 P.M.				
6. SEX Female					7. RACE White				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					C. CITY OR TOWN Baltimore				
9. DATE OF BIRTH DEC. 10, 1965					10. AGE (In years last birthday) 6				
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND					12. CITIZEN OF WHAT COUNTRY? USA				
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT					14B. KIND OF BUSINESS OR INDUSTRY SCHOOL				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO					17. SOCIAL SECURITY NO.				
18. INFORMANT MRS. INGE BARRON, 2100 W. ROGERS AVE. #21209					ADDRESS				
19. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
20A. DATE OF OPERATION									
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED									
21. AUTOPSY? (Yes or No) No									
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street									
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Cross Country Road & South Road									
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 8-9-72 11:40 P.									
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>									
22F. HOW DID INJURY OCCUR? Passenger in auto-auto collision									
23.									
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Marvin S. Platt, M.D.									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>									
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>									
DATE SIGNED August 10, 1972									
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL									
24B. DATE 8/10/72									
24C. NAME OF CEMETERY or CREMATORY BETH TFILOH									
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND									
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972									
25B. NAME OF REGISTRAR Sidney [Signature]									
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD									
ADDRESS									

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FARMERS' UNION

MONTGOMERY A. FARMER

THE FARM

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THE FARM

THE FARM, 1100 N. W. 11th St., Miami, Fla.

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THE FARM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 07708</u>	
BIRTH NO. <u>10-523</u>				72 07708	
1. NAME OF DECEASED (Type or Print) <u>Weinstein Ida E.</u>				2. DATE AND HOUR OF DEATH <u>8/9/72</u> <u>11:4</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY Hospital</u>				A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>3724 PIKESWOOD DRIVE</u>					
5. SEX <u>FEMALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>10-8-1916</u>		9. AGE (in years last birthday) <u>55</u>		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH SNYDER</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE WEINBERG</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>212-09-7607</u>	
17. INFORMANT <u>MR. PHILIP A. WEINSTEIN</u>				ADDRESS <u>3724 PIKESWOOD DR.</u>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Rheumatic heart disease</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 yr.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>disease</u>	
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>8/7/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Rheumatic heart disease</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/9</u> 19 <u>72</u> to <u>8/9</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/9</u> 19 <u>72</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stephen J. Toney</u>				23B. DATE SIGNED <u>8/9/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Stephen J. Toney</u>				23D. ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/11/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>MIKRO KODESH</u>	
24D. LOCATION <u>BALTIMORE, MARYLAND</u>		24E. ADDRESS <u>BALTIMORE, MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 14 1972</u>		25B. NAME OF REGISTRAR <u>Stephen J. Toney</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS.</u>	

1944-1945
1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

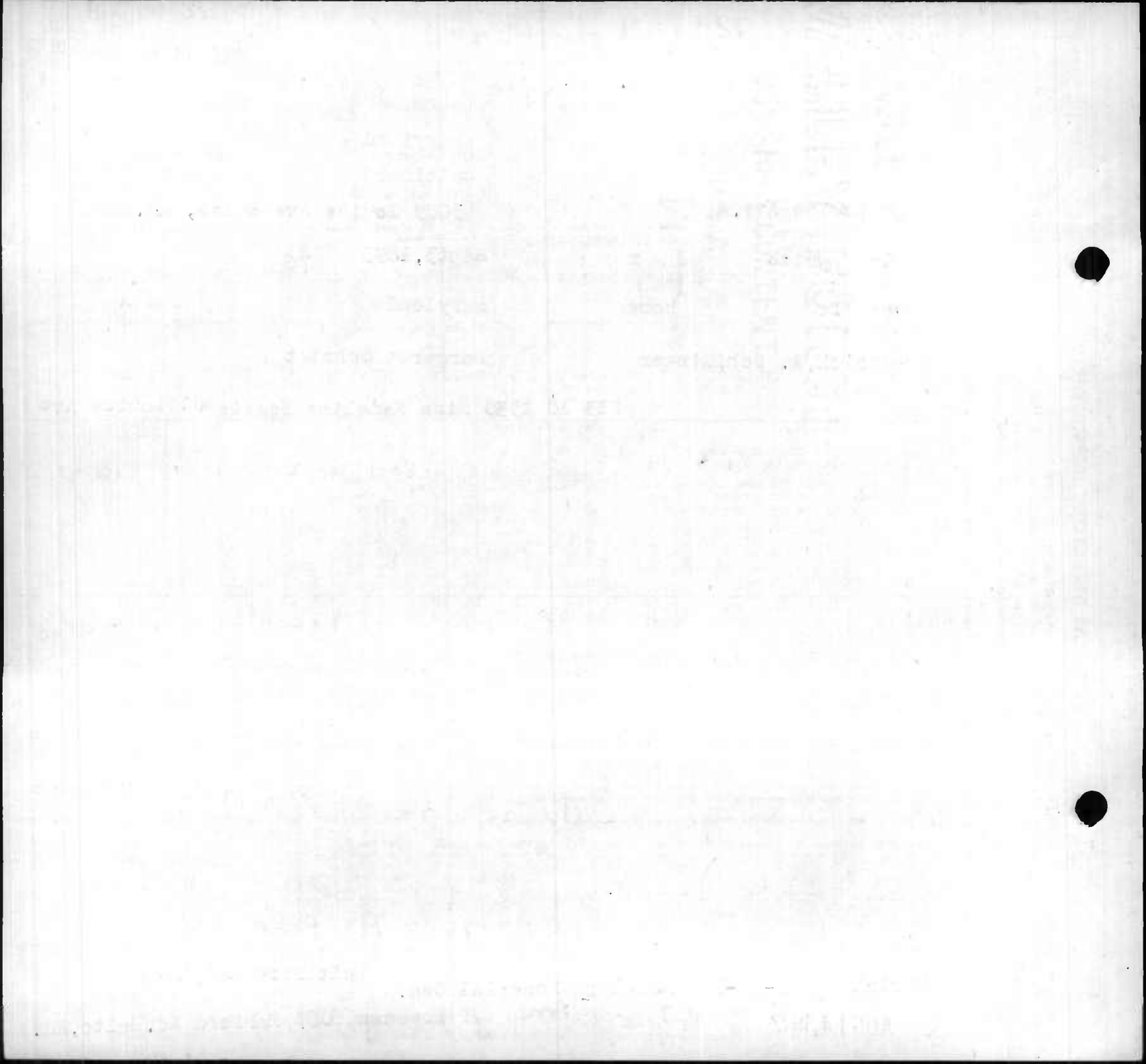
1944-1945

1944-1945

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. P-200		BALTIMORE CITY HEALTH DEPARTMENT 72 07709 CERTIFICATE OF DEATH		REG. NO. 72 07709	
1. NAME OF DECEASED (Type or Print) Gertrude A. Poggie			2. DATE AND HOUR OF DEATH 8-9-72 3 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2745		
FULL NAME OF HOSPITAL OR INSTITUTION 08			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3009 Louige Ave.			E. STREET AND NUMBER 3009 Louise Ave Balto, Md. 21214		
5. SEX female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 3, 1895	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Frederick A. Schiminger			12. CITIZEN OF WHAT COUNTRY? U S A		
14. MOTHER'S MAIDEN NAME Margaret Schmidt			17. INFORMANT Miss Madeline Poggie		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 213 10 1350		
18. 43791 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral arteriosclerosis 10 year		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Peptic ulcer 2 years		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 51 to Aug. 9, 19 72 , that (I) (we) last saw the deceased alive on July 25, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE R Donald Jandorf DEGREE				23B. DATE SIGNED 8-9-72	
23C. PHYSICIAN'S NAME (Type) R Donald Jandorf DEGREE				23D. ADDRESS 7403 Harford Rd	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 8-12-72		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972			
25B. NAME OF REGISTRAR Sidney H. Hinton		25C. FUNERAL DIRECTOR P. Heemann			
ADDRESS 6067 Harford Rd. Balto, Md.					



CERTIFICATE OF DEATH

REG. NO. 72 07710

STATE OF MARYLAND - D.H.M.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LEWIS, ALDA M.

2. DATE AND HOUR OF DEATH
AUGUST 7 1972

1:40P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

BALTIMORE
903 JOH AVE. 21229

5. SEX

FEMALE

6. RACE

CAUCASIAN

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

09-24-1886

9. AGE (In years
last birthday)

85

If Under 1 Yr.

Months Days Hours Min.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

OHIO

13. FATHER'S NAME

~~UNKNOWN~~

William R. McKnight

14. MOTHER'S MAIDEN NAME

~~UNKNOWN~~

Nellie Lambert

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

WILKENS & CATON AVE. 21229

ST AGNES HOSPITAL RECORDS -

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

18. 436.91

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) C.V.A.

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐Not While ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ☒ (this hospital) attended the deceased from AUGUST 7 1972 to AUGUST 7 1972,
that ☒ (we) last saw the deceased alive on AUGUST 7 1972 and that in ☒ (our) opinion death occurred on the date
and hour and from the causes stated above. ☒ (We) (did) (did not) view the body after death.

23A. SIGNATURE

F. Khorsani

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

08 07 72

23C. PHYSICIAN'S
NAME (Type)

F KHORSANI

23D. ADDRESS

ST AGNES HOSPITAL - WILKENS & CATON

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-10-1972

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

24D. LOCATION

(City, town, or county) AVE (State)

Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 14 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Avenue

ADDRESS

21229

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1042

LEWIS, ALMA

AUGUST 7 1975

1042

ST. AGNES HOSPITAL

BALTIMORE

N. 903 10th AVE. 21229

FEMALE CAUCASIAN

1042

HOUSE 102

OHIO

1042

NOT KNOWN

UNKNOWN

ST. AGNES HOSPITAL RECORDS -
WILKINS & CATON AVE. 21229

1042

1042

AUGUST 7 1975

1042

AUGUST 7 1975

1042

1042

1042

7 KHORSANI

ST. AGNES HOSPITAL - WILKINS & CATON

1042

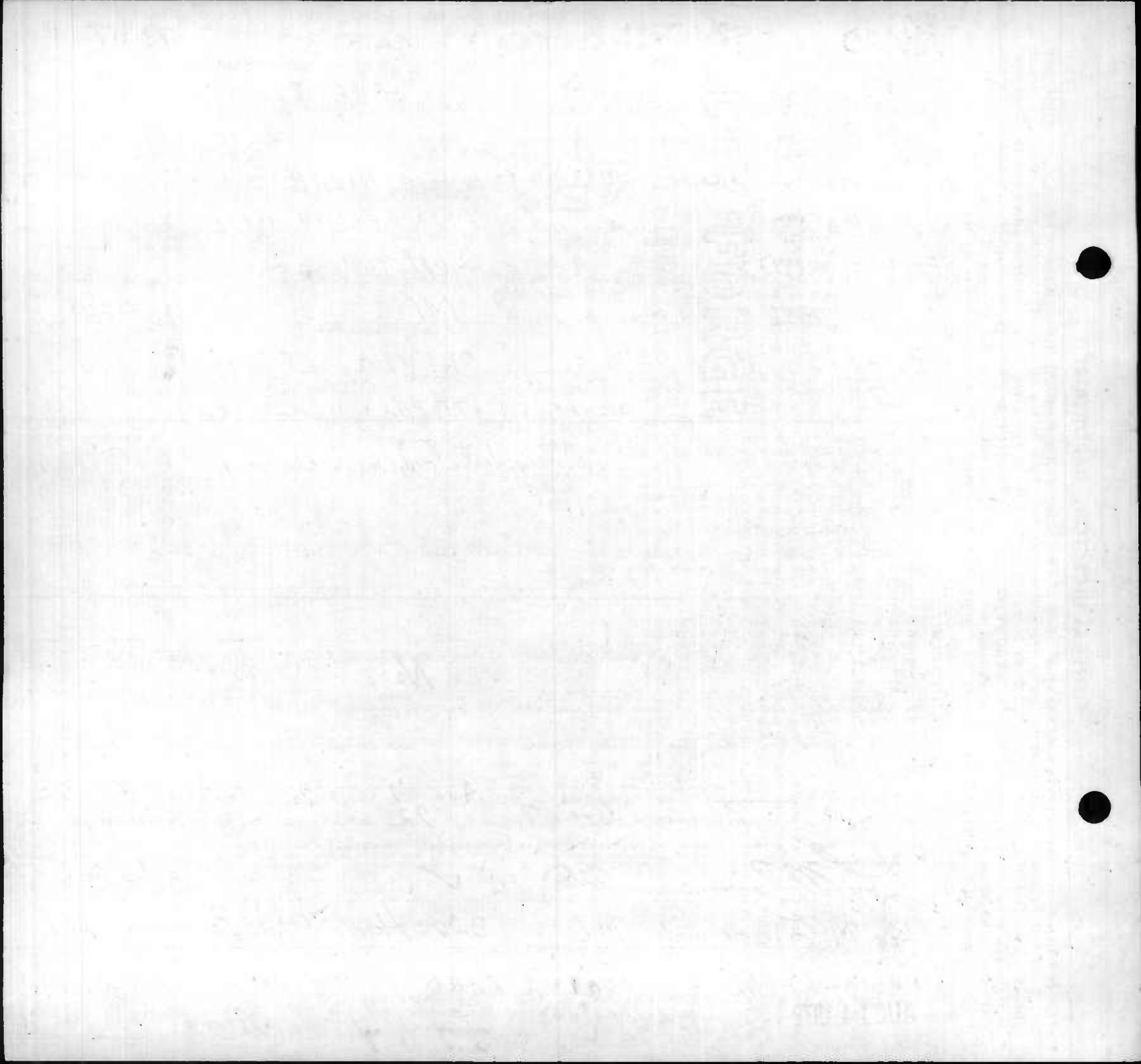
1042

1042

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

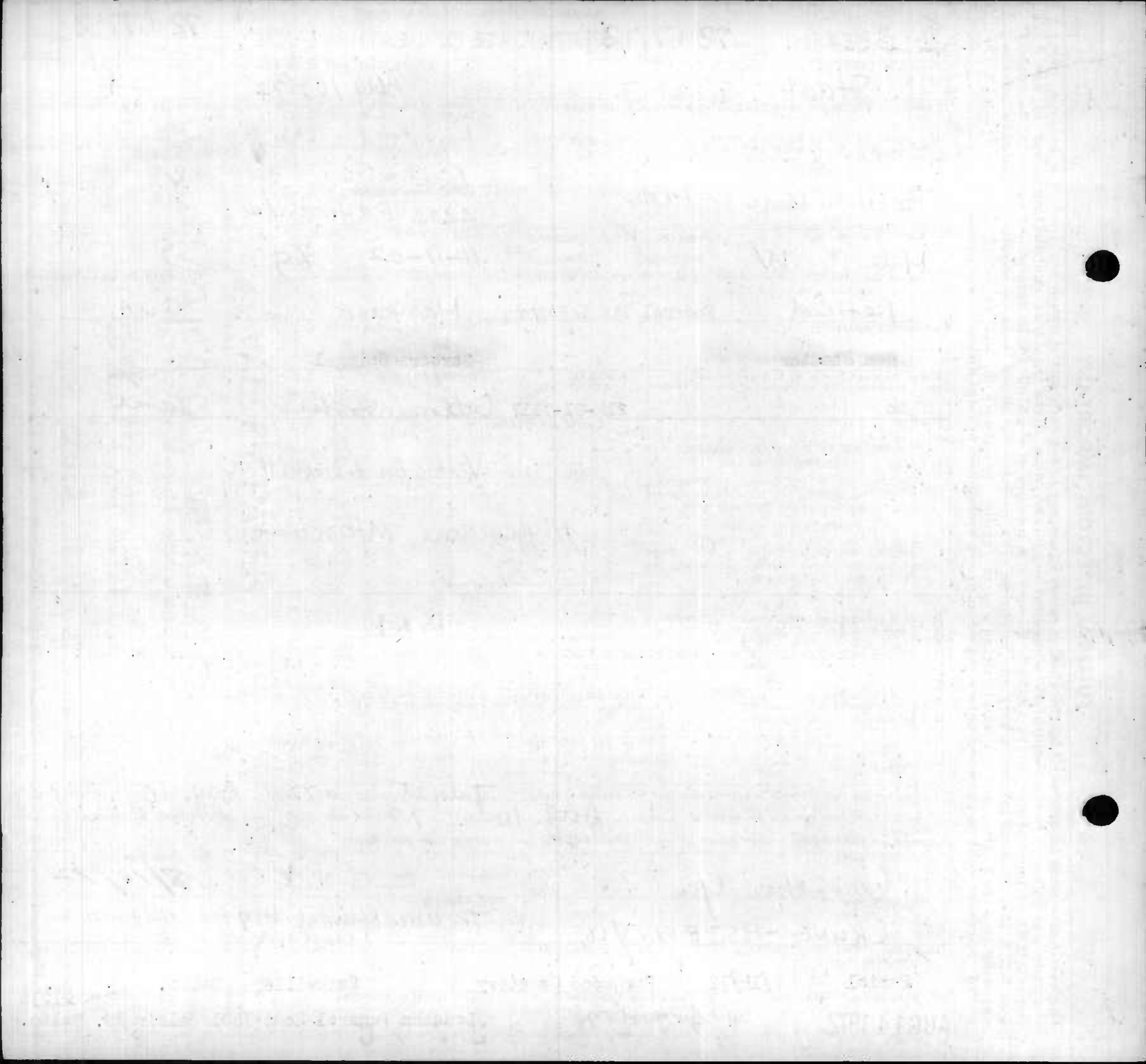
BALTIMORE CITY HEALTH DEPARTMENT									
K-620 72 07711 CERTIFICATE OF DEATH					REG. NO. 72 07711				
BIRTH NO. 1. NAME OF DECEASED (Type or Print) LOUISE G KIRK					2. DATE AND HOUR OF DEATH AUG. 8, 1972 7:00 A. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HARFORD GARDENS NURSING HOME 4700 HARFORD RD.					A. STATE MD. B. COUNTY BALTO. 20 5300				
C. CITY OR TOWN MIDDLE RIVER					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
E. STREET AND NUMBER 1412 SECOND RD.									
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 12/11/1909		9. AGE (In years last birthday) 62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ADMINISTRATOR		10B. KIND OF BUSINESS OR INDUSTRY HARFORD GARDEN NURSING HOME		11. BIRTHPLACE (State or foreign country) MD.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME FRANK BLADES					14. MOTHER'S MAIDEN NAME OLIVIA PHILLIPS				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -					16. SOCIAL SECURITY NO. 219-07-5857		17. INFORMANT ATT. EDWARD AZRAEL		
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 years									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Aug. 1 19 72 to Aug 8 19 72, that (I) (we) last saw the deceased alive on Aug 7 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.									
23A. SIGNATURE [Signature] DEGREE					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 8/8/72	
23C. PHYSICIAN'S NAME (Type) Key M. Zimmerman M.D. DEGREE					23D. ADDRESS 3202 Harford Rd. Baltimore, MD.				
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 8/11/72		24C. NAME OF CEMETERY or CREMATORY LORRAINE PARK			24D. LOCATION (City, town, or county) (State) WOODLAWN BALTO MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972					25B. NAME OF REGISTRAR [Signature]			25C. FUNERAL DIRECTOR ADDRESS Connolly Funeral Home, Middle, 21	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07712
72 07712 CERTIFICATE OF DEATH				STATE OF MARYLAND
BIRTH NO. 5-336		1. NAME OF DECEASED (Type or Print) Stadter, Joseph J.		
2. DATE AND HOUR OF DEATH Aug 10, 72 12:48		M. 48		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hosp.		A. STATE Maryland		
(If not in hospital or institution, give street address or location)		B. COUNTY 2631		
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 4404 Bayonne Ave.				
5. SEX Male	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-02	9. AGE (In years last birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Federal Tin & Paper Co.		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ben Stadter		
14. MOTHER'S MAIDEN NAME Barbara Spiegel		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 214-01-7117		17. INFORMANT Catherine Stadter ADDRESS Same		
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				
(This does not mean the mode of dying, a.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				
18B. ANTECEDENT CAUSES				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION Aug 10, 72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from July 25 19 72 to Aug. 10 19 72 , that (I) (we) last saw the deceased alive on Aug. 10 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Chung-Hsiang Yu				23B. DATE SIGNED 8/10/72
23C. PHYSICIAN'S NAME (Type) CHUNG-HSIANG YU				23D. ADDRESS The Union Memorial Hospital, Baltimore
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/72		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery
24D. LOCATION Parkville Balto. Md.		24E. ADDRESS 21236		
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Lassahn		25C. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Rd. Balto.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. STATE OF MARYLAND-DHMH
J-525 72 07713		72 07713		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Johnson, McNEAL (McNeil)		8/13/72 2 A-M		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
		1706 W. Mosher Street Md.		
Lutheran Hospital of Md.		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		1706 W. Mosher Street 1603		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7-3-95	77 yrs
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
LONG SHOREMAN				Charleston, S.C.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
UNK		UNK		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
Yes. 10/3/18-5/24/19		215-09-3454		Mrs. Araminta Johnson 2327 Windsor Ave.
18. 43691		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		PULMONARY		
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF: EMBOLISM		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CEREBROVASCULAR		
		DUE TO, OR AS A CONSEQUENCE OF: ACCIDENT		
		(C) ANEMIA		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 7/20/1972 to 8/13/1972, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
J. Sanders		8/13/72		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
E. SANDOZ				
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	8/15/72	Arbutus Mem. Park	Baltimore	Maryland
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS		
AUG 14 1972	Sidney W. Workman	Morton & Dyett F.H. 1701 Laurens St.		

10/18-2/24/19

424E-PO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> H-640 72 07714 </div>		<div style="display: flex; justify-content: space-between;"> CITY HEALTH DEPARTMENT STATE OF MARYLAND-DEM </div>	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. CERTIFICATE OF DEATH </div>		<div style="display: flex; justify-content: space-between;"> REG. NO. 72 07714 </div>	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
HOERL, CHARLES JOSEPH		AUGUST 10, 1972 5:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE, MARYLAND 21229		A. STATE MARYLAND	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		B. COUNTY BALTO	
5. SEX MALE		6. RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 06-29-94	
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-PAINTER	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AUGUST HOERL		14. MOTHER'S MAIDEN NAME MARGARET (FLANIGAN)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.1		16. SOCIAL SECURITY NO. 212076837	
17. INFORMANT ST. AGNES HOSPITAL, WILKENS & CATON AVE.		ADDRESS BALTO. MD. 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE cachexia & anemia DUE TO, OR AS A CONSEQUENCE OF: (B) Malignancy DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUGUST 07 19 72 to AUGUST 10 19 72, that (I) (we) last saw the deceased alive on AUGUST 10 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Donald T. Rowe M.D.		23B. DATE SIGNED 08/10/72	
23C. PHYSICIAN'S NAME (Type) DONALD T. ROWE M.D.		23D. ADDRESS BALTO. MD. 21229 ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/72	
24C. NAME OF CEMETERY or CREMATORY Gettysburg National		24D. LOCATION (City, town, or county) (State) Gettysburg, Penna.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Edw. S. MacNabb Sons, Inc.	
25C. FUNERAL DIRECTOR ADDRESS 301 Frederick Rd. Catonsville, Md.		25D. NAME OF REGISTRAR Edw. S. MacNabb Sons, Inc.	

ROBERT, CHARLES JOSEPH AUGUST 10, 1922

MARYLAND
BALTIMORE
ST. AGNES HOSPITAL
WICKENS & CO. TON, VIRGINIA
BALTIMORE, MARYLAND 21220 BY BLOOMSBURY AVENUE

06-22-24
WHITE
RETIRED-PAINTER SELF EMPLOYED
MARYLAND U.S.A.

DEPT ROBERT
MARGARET (PLUMMER)
BALTIMORE
ST. AGNES HOSPITAL, WICKENS & CO. TON, VIRGINIA

AUGUST 07 1972
AUGUST 10 1972

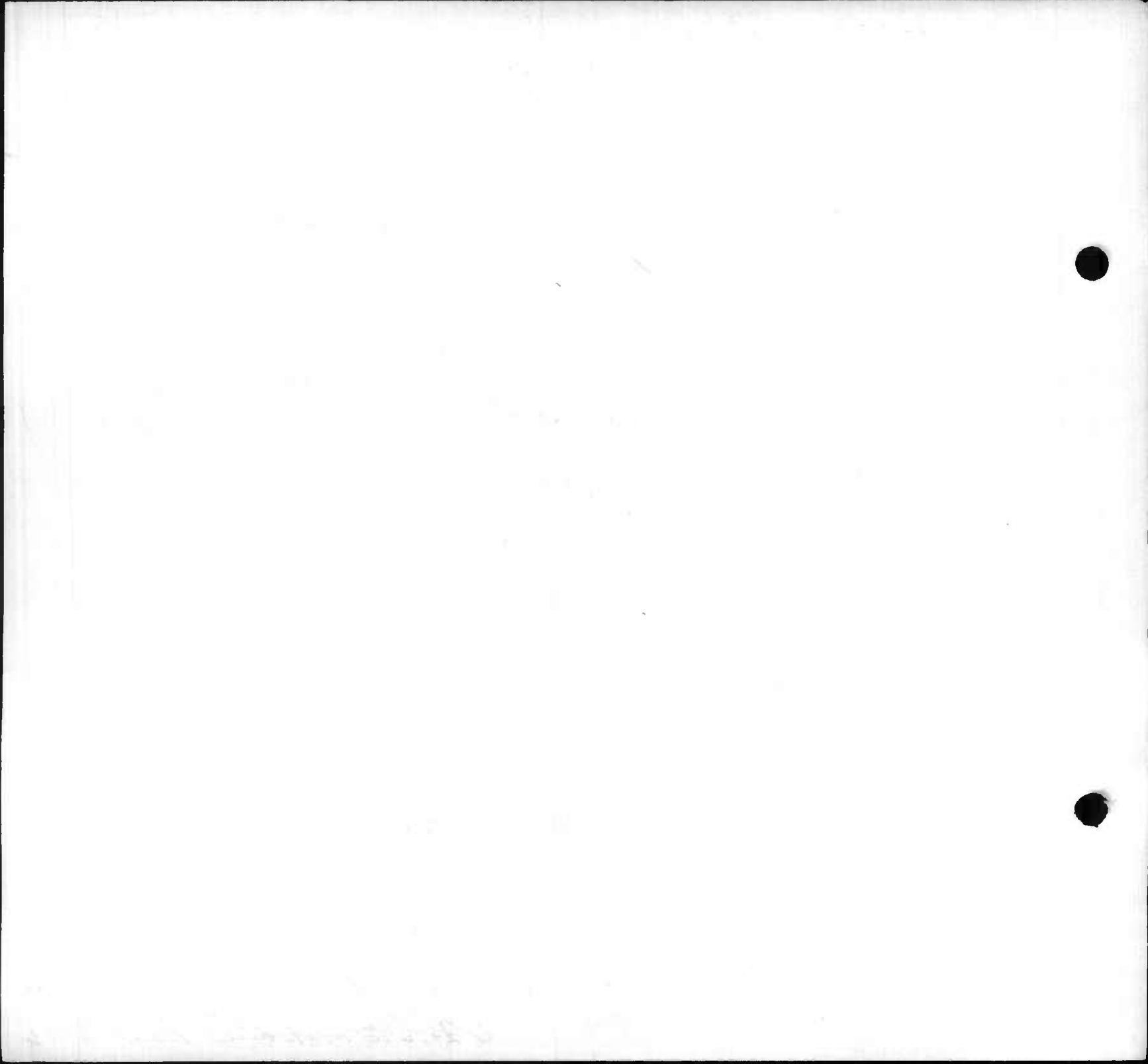
ST. AGNES HOSPITAL, WICKENS & CO. TON, VIRGINIA
BALTIMORE, MARYLAND 21220

Butler 8/15/72 Georgetown National
301 Robinson St. Georgetown, Md.
301 Robinson St. Georgetown, Md.
301 Robinson St. Georgetown, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

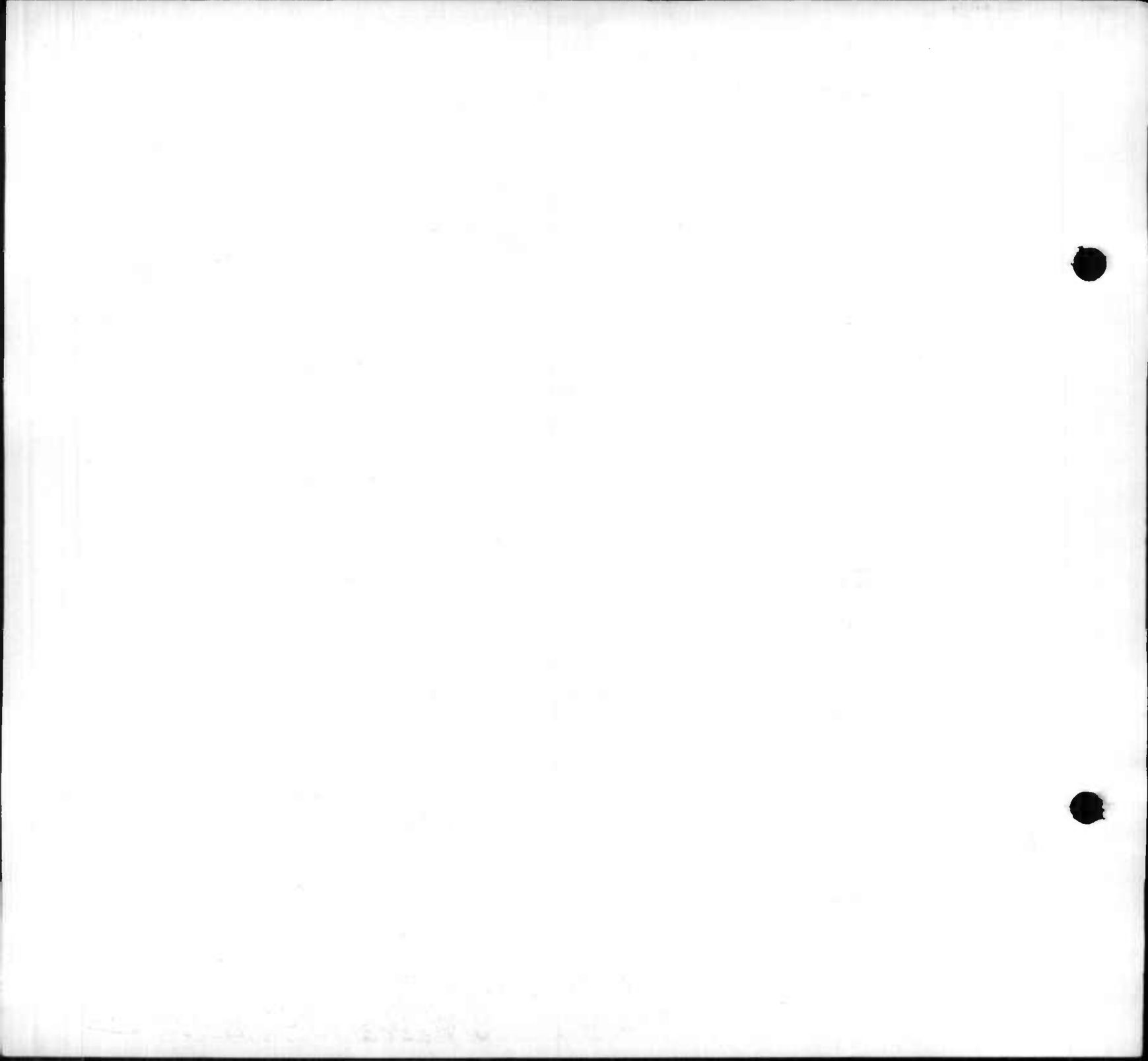
H-553 72 07715		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 07715
BIRTH NO.		STATE OF MARYLAND-DHMH		
1. NAME OF DECEASED (Type or Print) <i>EVA HAMMOND</i>		2. DATE AND HOUR OF DEATH <i>AUG 13 / 72 3:40 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>LUTHERAN HOSPITAL</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>1601</i>		
5. SEX <i>F</i> 6. RACE <i>N</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH <i>4-2-1896</i> 9. AGE (in years last birthday) <i>76</i>		
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		
13. FATHER'S NAME <i>K</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>2 18-16134</i>		
18. <i>199.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <i>CARDIO RESPIRATORY ARREST</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <i>CANCER, METASTATIC</i>		17. INFORMANT <i>Mary 3 Hammond</i> ADDRESS <i>1118 1/2 Franklin St. Bost 332</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <i>8-13-72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>7-9-72</i> to <i>8-13-72</i> that (I) (we) last saw the deceased alive on <i>8-13-72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Ruben Manriquez M.D.</i>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>RUBEN MANRIQUEZ M.D.</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/18/72</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt Calvary</i>
24D. LOCATION (City, town, or county) <i>Baltimore Md</i>		24E. LOCATION (State) <i>Md</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 14 1972</i>		25B. NAME OF REGISTRAR <i>Edna H. Hinton</i>		25C. FUNERAL DIRECTOR <i>3956 N. ...</i> ADDRESS <i>Bost 214</i>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
C-150		72 07716		72 07716	
1. NAME OF DECEASED (Type or Print)		CHAFFIN IRENE		2. DATE AND HOUR OF DEATH 8-13-72 6:40 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION U. of Md. Hospital 38		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		727 Druid Hill LAKE DR Baltimore Maryland 1301	
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-20-02	9. AGE (In years last birthday) 68-70	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Walter CHAFFIN (dec)		14. MOTHER'S MAIDEN NAME EUA (dec)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Cardiac Arrest 20 mins	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ASCVD, Chronic Renal Failure DUE TO, OR AS A CONSEQUENCE OF:			
(C) Gram Negative Sepsis, Diabetes					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		As above			
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/11 1972 to 8/13 1972 that (I) (we) lost saw the deceased alive on 8/13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE F. G. Miranda, M.D.		23B. DATE SIGNED 8-13-72		23C. PHYSICIAN'S NAME (Type) F. G. Miranda, M.D.	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 8/18/72		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery	
24D. LOCATION Baltimore Md		24E. ADDRESS 3915 Juniper Rd, Balto, Md 21218		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR F. G. Miranda		25C. FUNERAL DIRECTOR F. G. Miranda	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. ~~STATE OF MARYLAND-DHM~~

VS 151-REV. 7/1/6B

17-12-59

17-12-59

17-12-59

17-12-59

17-12-59

17-12-59

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07718		REG. NO. 72 07718	
BIRTH NO.				STATE OF MARYLAND-DEME			
1. NAME OF DECEASED (Type or Print) JOHN J. WILEY				2. DATE AND HOUR OF DEATH 8-11-72 14:10 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL HOSP. BALTO., MD.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 843			
5. SEX MALE				6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY BALTO. CITY POLICE		8. DATE OF BIRTH 12-5-89		9. AGE (In years last birthday) 82	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME SAMUEL WILEY				14. MOTHER'S MAIDEN NAME MARY SANDNER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 220-44-4948		17. INFORMANT MRS. EVELYN M. ZAMPINI	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 151.91 CAUSE OF DEATH (A) IMMEDIATE CAUSE gastro carcinoma DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 8-11-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-21-72 to 8-11-72 and that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W.H. Bauberee MD				23B. DATE SIGNED 8-11-72		23C. PHYSICIAN'S NAME (Type) W.H. BAUBEREE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 8-14-72		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY	
24D. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD, BALTO. Co., MD.				25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972			
25B. NAME OF REGISTRAR Anthony J. Johnston				25C. FUNERAL DIRECTOR Charles A. Jailer			
25D. ADDRESS 901 S. CONKLING ST. BALTO., MD.							

THE NATIONAL ARCHIVES

MARYLAND GENERAL DEPT
BALTO, MD.

BALTIMORE

MALE WHITE

RETIRED

1928

82

2525 BERYL AVE #112

10A

John L. Jones

1

S-530

72 07719

BALTIMORE CITY HEALTH DEPARTMENT

72 07719

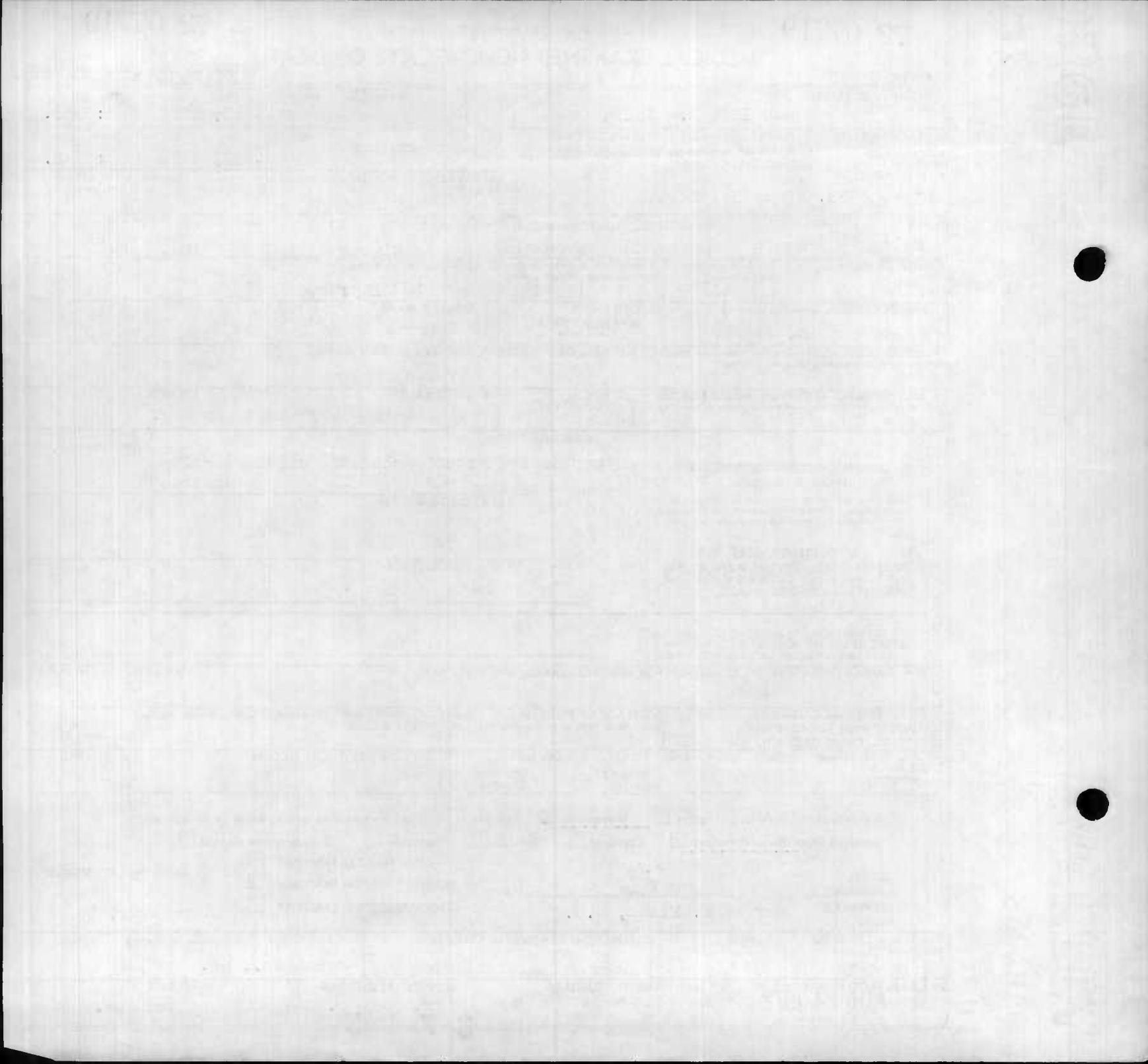
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. OF MARYLAND-DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LEWIS H. SMITH		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year August 12, 1972		Hour 5:03 P. M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year August 12, 1972		Hour 5:03 P. M.
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY BALTO 5300
9. DATE OF BIRTH 2/8/28		10. AGE (In years last birthday) 44	11. BIRTHPLACE (State or foreign country) Philadelphia, Penna.	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME Ambrose Smith		14. MOTHER'S MAIDEN NAME Gladys Stewart
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes WWII		17. SOCIAL SECURITY NO. 216-20-6086		18. INFORMANT Elaine Smith
19. CAUSE OF DEATH Hypertensive Arteriosclerotic cardiovascular disease		20. DATE OF OPERATION 8		21. AUTOPSY? (Yes or No) No

19. CAUSE OF DEATH Hypertensive Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)	
20A. DATE OF OPERATION 8		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Marvin S. Platt		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Marvin S. Platt, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/72	
24C. NAME OF CEMETERY or CREMATORY Garden of Eternal Hope		24D. LOCATION (City, town, or county) (State) Carol Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Adrienne H. Weston	
25C. FUNERAL DIRECTOR Mrs. Mary E. Law		ADDRESS 802 Madison Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07720	
CERTIFICATE OF DEATH				REG. NO. 72 07720	
BIRTH NO. 72 07720		1. NAME OF DECEASED (Type or Print) <u>JACKSON, Keitha</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>8/7/72</u> <u>3:50</u> P.M.			
FULL NAME OF HOSPITAL OR INSTITUTION <u>George Washington N.H.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>607 Pennsylvania Ave.</u>		A. STATE <u>md.</u>		B. COUNTY <u>1701</u>	
5. SEX <u>Female</u>		6. RACE <u>Black</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH <u>4/3/1906</u>		9. AGE (in years last birthday) <u>66</u>		10. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurses aide</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
13. FATHER'S NAME <u>John Wesley Sampson</u>		14. MOTHER'S MAIDEN NAME <u>Caroline McGee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>212078510</u>		17. INFORMANT <u>Chart</u>	
18. <u>250,91</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		<u>Diabetes Mellitus</u>			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE			
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		<u>Chronic Renal Failure</u>			
		<u>With Uremia</u>			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		<u>Malignant Hypertension</u>			
		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>24 JAN</u> 19 <u>72</u> to <u>7 Aug</u> 19 <u>72</u>		22. I certify that (1) (we) last saw the deceased alive on <u>4 Aug</u> 19 <u>72</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Richard Tyson, M.D.</u>		23B. DATE SIGNED <u>7 Aug 72</u>			
23C. PHYSICIAN'S NAME (Type) <u>Dr. Richard Tyson, M.D.</u>		23D. ADDRESS <u>936 West North Avenue</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/10/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 14 1972</u>		25B. NAME OF REGISTRAR <u>Lidney Houston</u>	
25C. FUNERAL DIRECTOR <u>Mary E. Law</u>		25D. ADDRESS <u>802 Madison Ave.</u>			

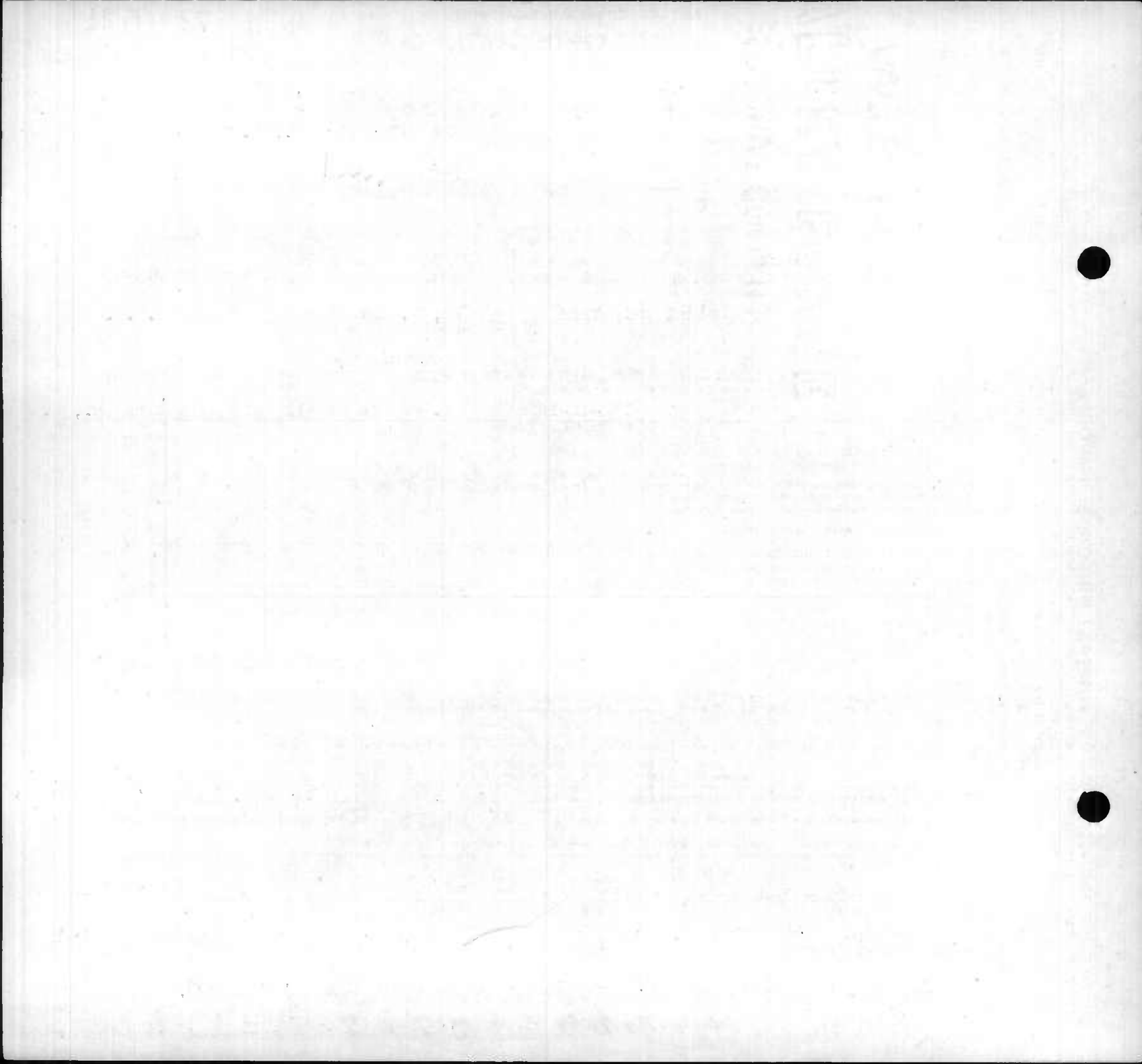
1/24/72 - Adm.
311 W. Biddle St.

CT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07721	
BIRTH NO. 72 07721				STATE OF MARYLAND-DMH	
1. NAME OF DECEASED (Type or Print) JAMES DUDLEY POWELL			2. DATE AND HOUR OF DEATH August 8, 1972		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE B. COUNTY 622 Allendale St., N. 1608 C. CITY OR TOWN Baltimore, md D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER		
5. SEX Male	6. RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/05/94	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Metal Ship Yard		11. BIRTHPLACE (State or foreign country) Wake, N. Carolina	
13. FATHER'S NAME Lee Powell			14. MOTHER'S MAIDEN NAME Louvenia		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 190-10-1656A		17. INFORMANT ADDRESS Mrs. Nannie Powell 622 Allendale St., N.	
18. 4369 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF: 2 weeks (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-13 1970 to July 19 1972 , that (I) (we) last saw the deceased alive on July 19 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Ralph M. Howard				23B. DATE SIGNED 8-10-72	
23C. PHYSICIAN'S NAME (Type) Ralph M. Howard, MD				23D. ADDRESS 926 W. North Ave Balto., Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/72		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Linda J. ...		25C. FUNERAL DIRECTOR ADDRESS MRS. Mary E. Law - 802 Madison	



1
C-120

72 07722

BALTIMORE CITY HEALTH DEPARTMENT

72 07722

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. OF MARYLAND DEPT. STATE OF MARYLAND

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		AUGUST GIBBS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year August 13, 1972		Hour 1:15 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		3. DATE PRONOUNCED DEAD		Month Day Year August 13, 1972		Hour 1:15 A.M.		5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE South Carolina B. COUNTY V37			
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Monks Corner		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH May 24, 1944		10. AGE (In years last birthday) 28		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Enoch Gibbs			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Florence Chiskolm		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO					
17. SOCIAL SECURITY NO.		18. INFORMANT Elizabeth Palmer		ADDRESS Box 73 Monks Cor. S.C.		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 1400 block Ensor Street		22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 8-13-72 12:30 A.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot by unknown assailant			
23. I certify that I held an inquiry <input type="checkbox"/> inspection <input type="checkbox"/> autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Marvin S. Platt</u> M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 13, 1972											
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/19/72		24C. NAME of CEMETERY or CREMATORY Nazareth Cemetery		24D. LOCATION (City, town, or county) (State) Monks Corner S.C.					
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Dorothy W. Hinton		25C. FUNERAL DIRECTOR Mrs. Mary E. Law		ADDRESS 802 Madison Ave					

May 24, 1914

Wm. A.

Busch C. 1882

Florence Christman

Elizabeth Tolman, Box 23 West

General 21st Street, New York City

Mr. Wm. A. Busch

FUNERAL DIRECTOR: IMPORTANT

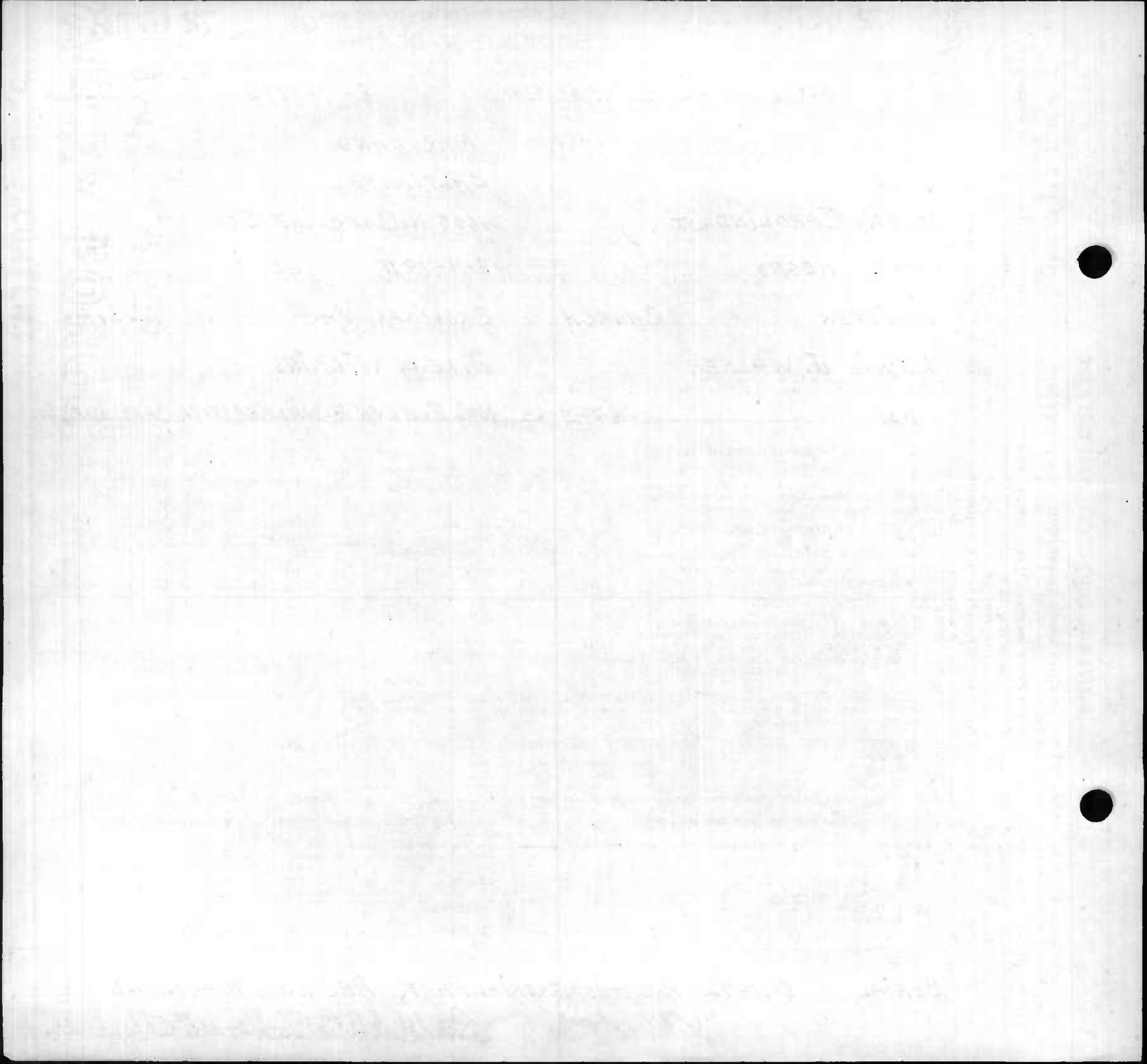
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 07723</u>	
<div style="display: flex; justify-content: space-between;"> B-65 1 72 07723 STATE OF MARYLAND-DEME </div>					
1. NAME OF DECEASED (Type or Print) <u>BRUNT ROSETTA</u>		2. DATE AND HOUR OF DEATH <u>8/9/72</u> <u>3:10 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1606</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIV. OF MD HOSPITAL</u>		C. CITY OR TOWN <u>CITY</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2864 W. LANVALE ST</u>			
5. SEX <u>F</u>	6. RACE <u>Ngr</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/11/31</u>	9. AGE (in years last birthday) <u>40</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Josephine Smarr</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. Lawrence A. Brunt - 2864 W. Lanvale St</u>			
18. <u>30391</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Hypertensive stroke</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>8/9/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>8/8/72</u> 19 <u>72</u> to <u>8/9</u> 19 <u>72</u> that (1) (we) last saw the deceased alive on <u>8/8</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>L. A. Fleming MD</u>		23B. DATE SIGNED <u>8/9/72</u>		23C. PHYSICIAN'S NAME (Type) <u>L. A. FLEMING</u>	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>8/14/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Calvary Cemetery Balto.</u>		24D. LOCATION (City, town, or county) <u>MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 14 1972</u>		25B. NAME OF REGISTRAR <u>Gladys Williams</u>		25C. FUNERAL DIRECTOR <u>Mrs. Mary E. Law - 802 Madison Ave</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

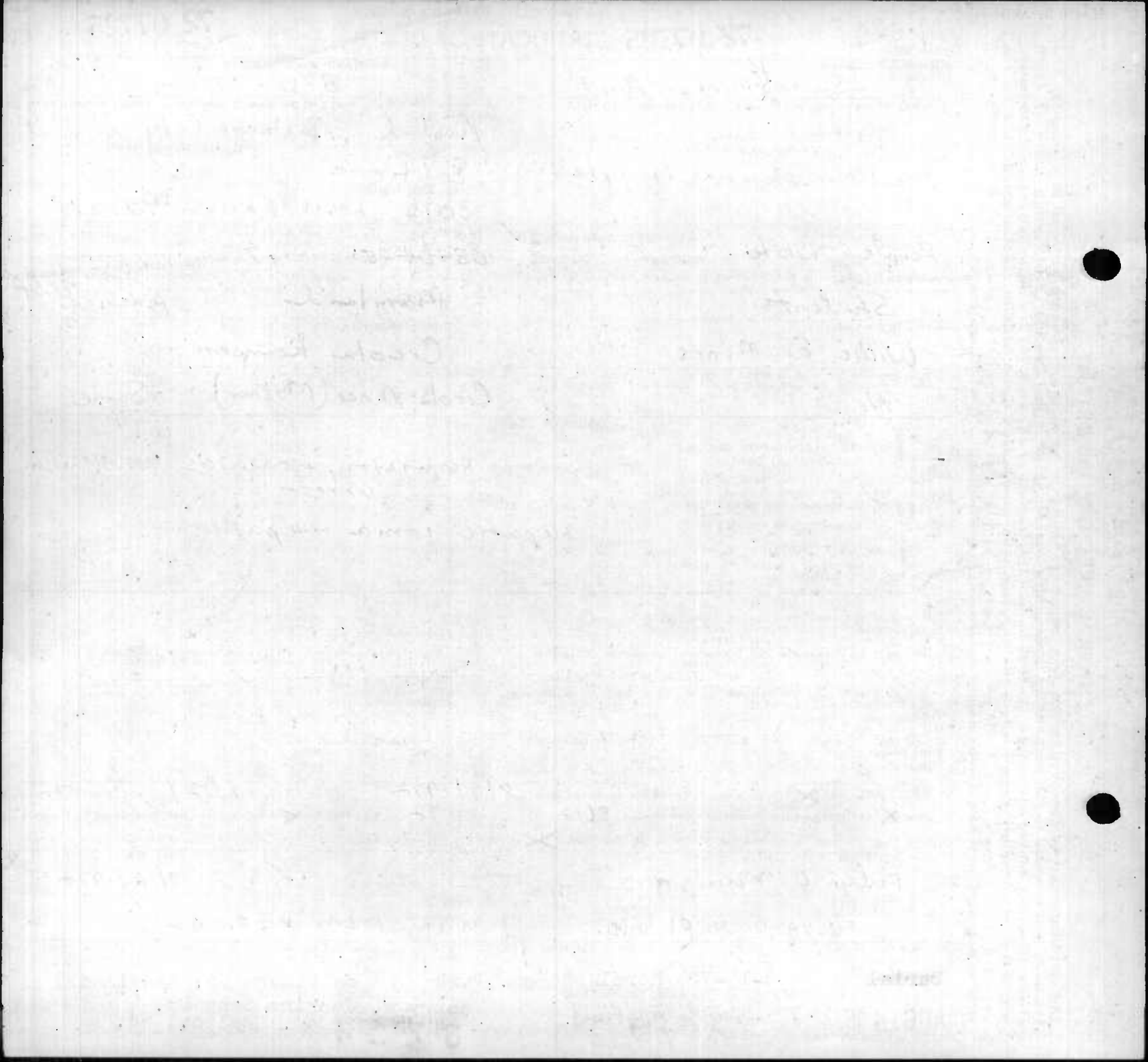
BIRTH NO. 72 07724				BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH				REG. NO. 72 07724			
1. NAME OF DECEASED (Type or Print) <u>CLEOPHIS S. WALKER</u>				2. DATE AND HOUR OF DEATH <u>8-7-1972</u>				STATE OF <u>MARYLAND</u> <u>DEPT</u>				M. <u>6:28</u> A.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				A. STATE <u>MARYLAND</u>				B. COUNTY <u>806</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1807 N. CAROLINE ST.</u>				C. CITY OR TOWN <u>BALTIMORE</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>1807 N. CAROLINE ST.</u>				5. SEX <u>MALE</u> 6. RACE <u>NEGRO</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>8-9-1911</u> 9. AGE (In years last birthday) <u>60</u>				If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>CHURCH</u>				11. BIRTHPLACE (State or foreign country) <u>BROADNAX, VA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>LEWIS J. WALKER</u>				14. MOTHER'S MAIDEN NAME <u>ALLEAN WILKINS</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NA</u>				16. SOCIAL SECURITY NO. <u>26-49-5363</u>			
17. INFORMANT <u>MRS. EVELYN H. WALKER</u>				ADDRESS <u>1807 N. CAROLINE ST.</u>				18. <u>157.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH <u>Concussion</u>			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Concussion of Head</u>				(B) <u>Concussion of Head</u> 11 months				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>			
ANTECEDENT CAUSES				DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>NO</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 8</u> 19 <u>72</u> to <u>Aug 7</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>July 26</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				23A. SIGNATURE <u>Roland T. Smart Jr.</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>8/11/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>ROLAND T. SMART M.D.</u>				23D. ADDRESS <u>2300 GARRISON BLVD</u>											
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>8-11-72</u>				24C. NAME OF CEMETERY or CREMATORY <u>ARBUTHUS MEMORIAL PARK</u>				24D. LOCATION (City, town, or county) (State) <u>ARBUTHUS, MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 14 1972</u>				25B. NAME OF REGISTRAR <u>Sidney Wharton</u>				25C. FUNERAL DIRECTOR <u>Randolph Collick</u>				ADDRESS <u>2431 E. Oliver St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07725	
M-520 72 07725		STATE OF MARYLAND-DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Susan Mines (Miss)	
2. DATE AND HOUR OF DEATH 8-12-72 11 A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore City 904		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Union Memorial Hospital 44	
C. CITY OR TOWN, Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3012 Loch Raven Rd 21218		5. SEX Female 6. RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 08-04-55 9. AGE (In years last birthday) 17	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? American U.S.A.	
13. FATHER'S NAME Willie E. Mines		14. MOTHER'S MAIDEN NAME Creola Kemper	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Creola Mines (Mother)		ADDRESS Same	
18. 5-73.0 CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory + cardiac arrest	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hepatic coma - Hepatitis DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/7/1972 19 to 8/12/1972 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 8/12 19 72 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (not) view the body after death.			
23A. SIGNATURE Fulya O. Nuri, M.D.		23B. DATE SIGNED 8/12/1972	
23C. PHYSICIAN'S NAME (Type) FULYA O. NURI, M.D.		23D. ADDRESS UNION MEM. HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-15-72	
24C. NAME OF CEMETERY or CREMATORY Moreland Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Sidney H. Houghton	
25C. FUNERAL DIRECTOR Henry W. Jenkins Sons Co.		ADDRESS 4905 York Rd. Balto., Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
72 07726 CERTIFICATE OF DEATHSTATE OF MARYLAND-DEM
REG. NO. 72 07726

BIRTH NO. 525		1. NAME OF DECEASED (Type or Print) Charles M. Johnson		2. DATE AND HOUR OF DEATH 8-12-72 12:15 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY BALTO		5300	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 7608 Knollwood Rd.		21204			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-28-16	9. AGE (in years last birthday) 56	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10B. KIND OF BUSINESS OR INDUSTRY College Towson State		11. BIRTHPLACE (State or foreign country) Pittsburgh, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Johnson		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 128-07-4960		17. INFORMANT Mrs. Charles M. Johnson	
ADDRESS Same					
18. 153.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Carcinoma of caecum with generalized metastases ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Generalized metastases (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2/24/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of caecum		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 11 1972 to August 12 1972 that (I) (we) last saw the deceased alive on August 12 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Grafton Hersperger		23B. DATE SIGNED August 14, 1972		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) W. Grafton Hersperger, M.D.		23D. ADDRESS Medical Arts Bldg.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-16-72		24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Grds.	
24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland					
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR Henry W. Jenkins Sons 4905 York Rd. Baltimore, Md. 21212	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07727

BIRTH NO.

1. NAME OF DECEASED (Type or Print) L. Irvin Stinchcomb				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 8 9 72 M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD Month Day Year Hour 8 9 72 2:45 a. M.			
6. SEX male				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 25 Oct. 1922				10. AGE (In years lost birthday) 49		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.				13. FATHER'S NAME Irvin L. Stinchcomb			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W. 11				17. SOCIAL SECURITY NO. 214 14 1003			
18. INFORMANT Mrs. Elizabeth Smalter				ADDRESS Balto. Md. 1125 Scott St.			
19. CAUSE OF DEATH E 818.8 Craniocerebral injuries DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes = head only							
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Pratt & West Falls Way				22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 8 9 72 12:40 a.m.			
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR? Subject was riding on side of truck - fell off - wheel of truck ran over subject			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> head Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/9/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE Aug. 12, 1972			
24C. NAME of CEMETERY or CREMATORY Loudon Park Cem.				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972				25B. NAME OF REGISTRAR Sidney Whitson			
25C. FUNERAL DIRECTOR George J. Gonce				ADDRESS 4001 Ritchie Hwy.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital or institution. Also, if the direct or contributing cause of death is: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Death was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 07728</u>	
BIRTH NO. <u>L-520</u>		72 07728 CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>LYNCH, Pattie</u>		2. DATE AND HOUR OF DEATH <u>8/8/72 9:05 pm.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1509</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital 2600 Liberty St. Baltimore, Maryland</u>		C. CITY OR TOWN <u>BALTIMORE</u>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>4010 Fairfax Rd.</u>	
5. SEX <u>female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-6-1904</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>unemployed</u>	9. AGE (In years last birthday) <u>68</u>
		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Jonas White</u>		14. MOTHER'S MAIDEN NAME <u>MARY Eggs</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>246-38-1394</u>	17. INFORMANT <u>Celestia Adams</u> <u>4010 Fairfax Rd.</u>
		ADDRESS	
18. <u>404 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Uremia, heart disease</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hypertension, arteriosclerotic; Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/3/72</u> 19 <u>72</u> to <u>8/8/72</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Conrado E. Agustin</u>		23B. DATE SIGNED <u>8/8/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>CONRADO E. AGUSTIN</u>		23D. ADDRESS <u>DEGREE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>8-6-72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Brown Hill Cem. Durham, N.C.</u>		24D. LOCATION (City, town, or county) (State) <u>Durham, N.C.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 14 1972</u>		25B. NAME OF REGISTRAR <u>John H. Wilson</u>	
		25C. FUNERAL DIRECTOR <u>Kelson F. W. Bailey</u> <u>1348 Calhoun St.</u>	

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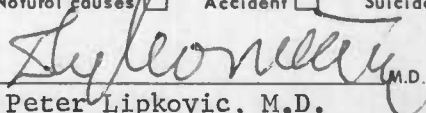
STATE OF MARYLAND
BALTIMORE CITY HEALTH DEPARTMENT

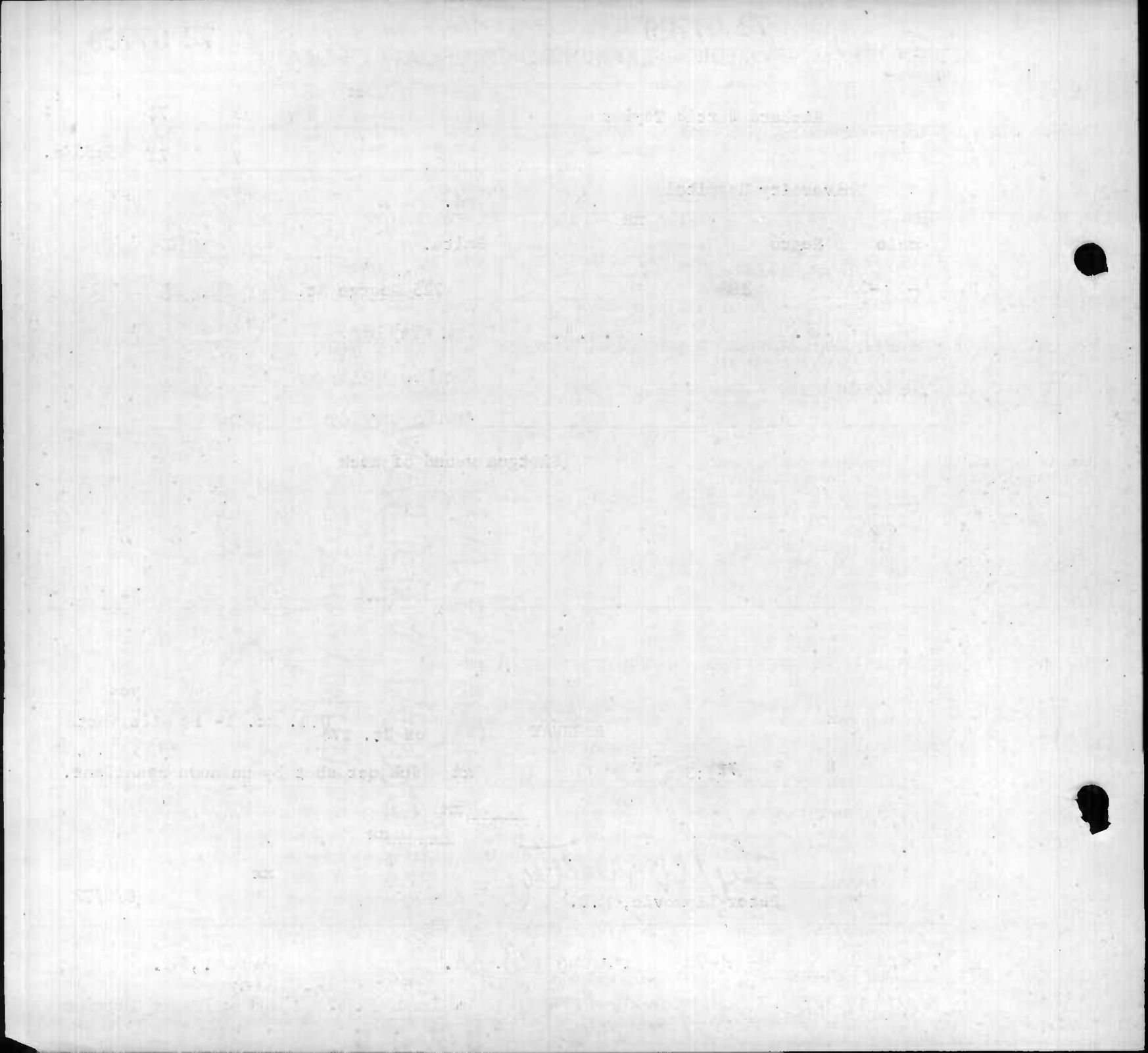
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Richard Curtis Taylor				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 8 Day 9 Year 72		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD Month 8 Day 9 Year 72		Hour 5:55 a.	
6. SEX male				7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 4-17-44				10. AGE (In years last birthday) 28		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Wm. Taylor		14. MOTHER'S MAIDEN NAME Eunice Wallace	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Annie Taylor				19. ADDRESS same		20. CAUSE OF DEATH Shotgun wound of neck	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E 9651 X				22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
24. DATE OF OPERATION 8-12-72				25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No) yes	
27. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HIGHWAY		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) U.S. Rt. 1- 1 1/2 mile North of Rt. 176	
30. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 8 9 72 1:30a				31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		32. HOW DID INJURY OCCUR? Subject shot by unknown assailant.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) Peter Lipkovic, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 8/9/72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-12-72		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Pk.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Audrey Whitson		25C. FUNERAL DIRECTOR V. Bailey ADDRESS Kelson F.H. 1348 Calhoun Street			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 07730 CERTIFICATE OF DEATH				REG. NO. 72 07730 STATE OF MARYLAND-DHMH	
BIRTH NO. B-500					
1. NAME OF DECEASED (Type or Print) MARIAN BOONE		2. DATE AND HOUR OF DEATH 8-3-72 1 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 1602			
		C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 903 N. WHATCOAT ST.			
5. SEX F	6. RACE N.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-34	9. AGE (in years last birthday) 37	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME Robt. Colvin		14. MOTHER'S MAIDEN NAME MARY HICKS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ROBT. COLVIN - 841 Ostend St.	
18. 571.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEPATIC COMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Laennec's Cirrhosis Alcoholism		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HEPATIC COMA (B) DUE TO, OR AS A CONSEQUENCE OF: Laennec's Cirrhosis (C) Alcoholism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-2 19 72 to 8-3 19 72 that (I) (we) last saw the deceased alive on 8-3-72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louise M. Victoria M.D.		23B. DATE SIGNED 8-3-72		23C. PHYSICIAN'S NAME (Type) Louise M. Victoria	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-11-72		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) BALTO., MD.		25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Adrienne H. H. H.	
25C. FUNERAL DIRECTOR V. Bailey		25D. ADDRESS 1348 Calhoun St.			

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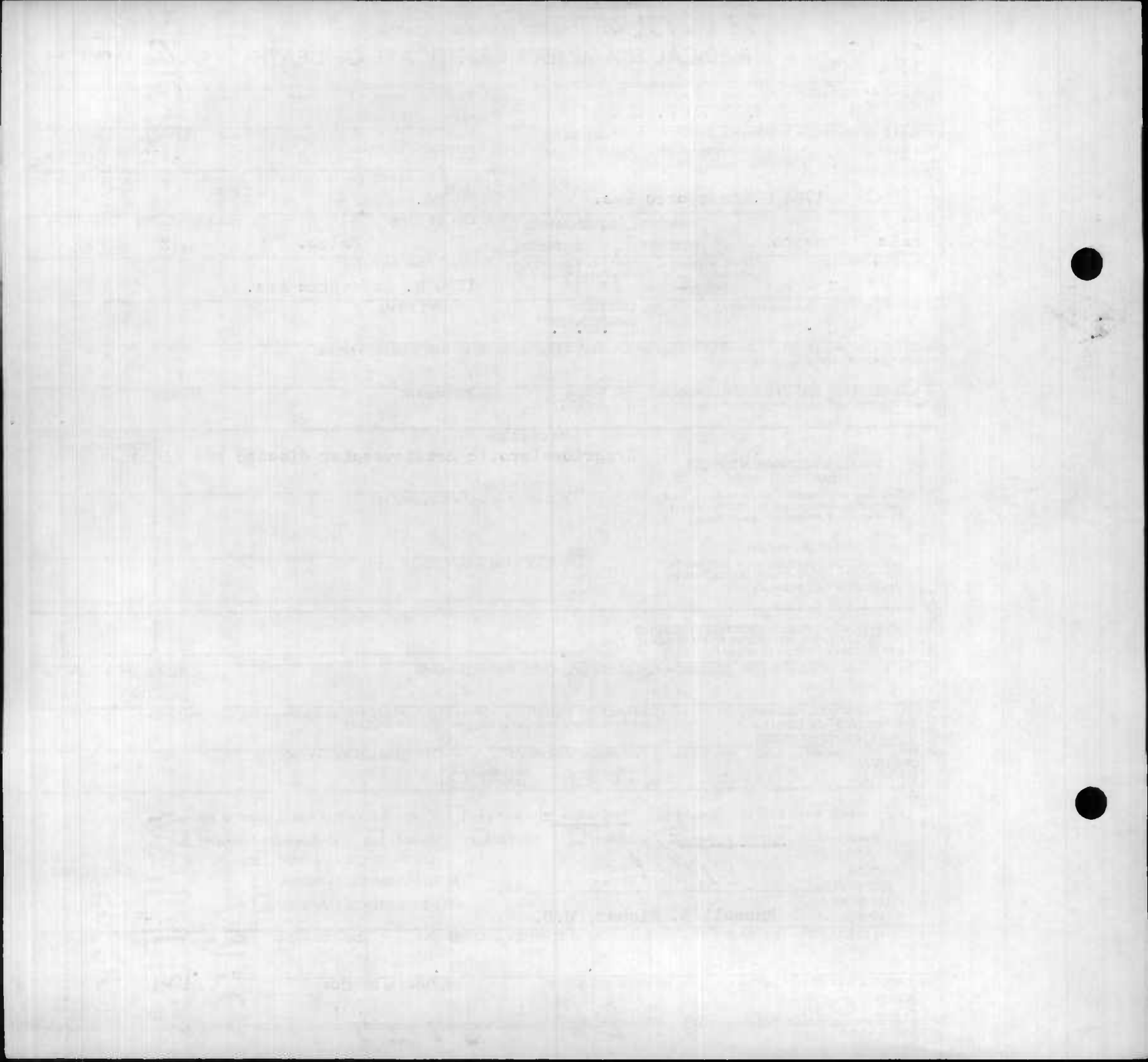
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07731

BIRTH NO.

REG. NO.

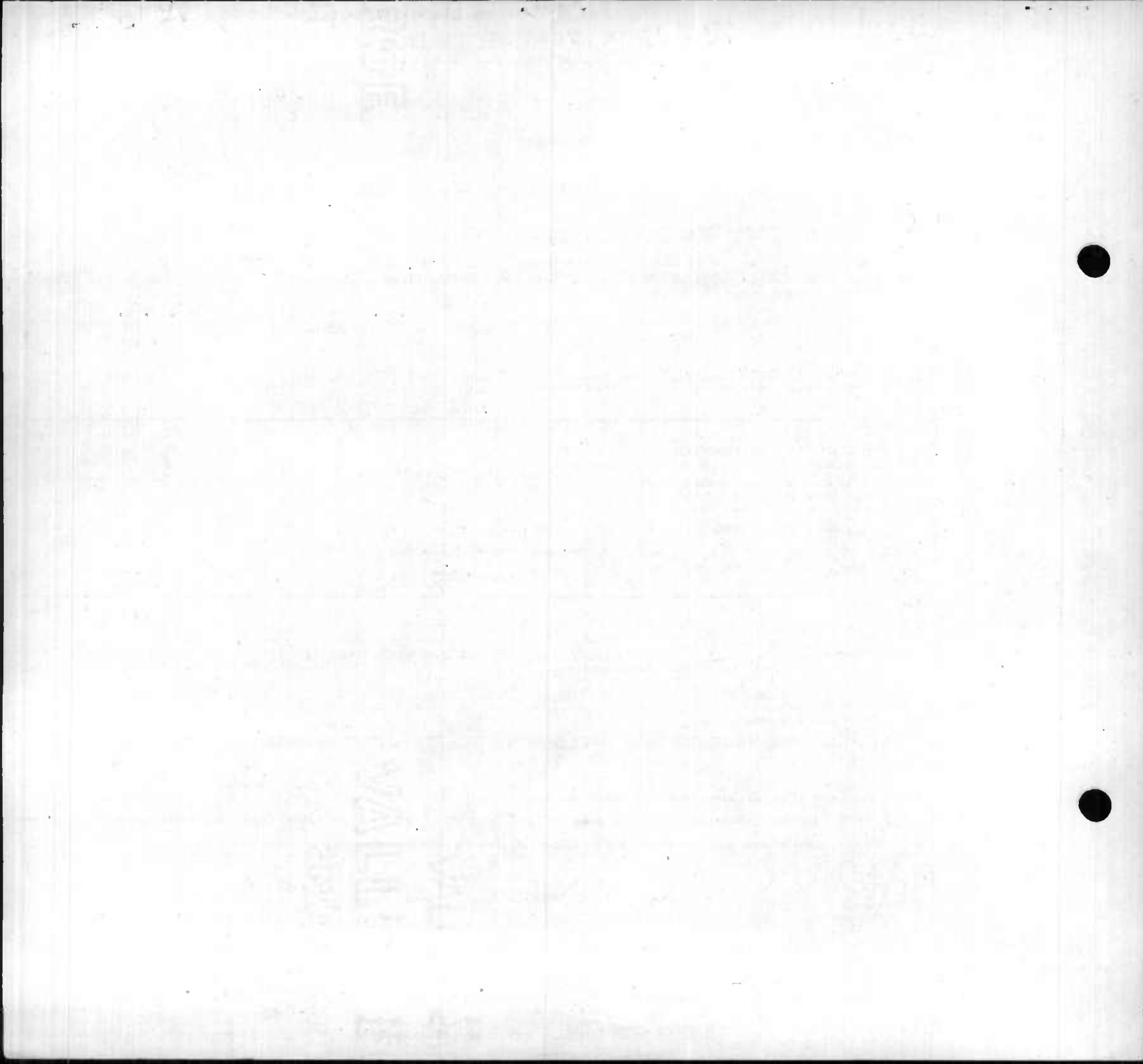
1. NAME OF DECEASED (Type or Print) RAYMOND E. BARNES		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1704 W. Lafayette Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 7 1972 8:25 a M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 9-12-09		10. AGE (In years last birthday) 62	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Annie Egerton	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 217078980A	
18. INFORMANT Victor Barnes		ADDRESS Box 314-Lexington Pk., Md.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease and diabetes ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Russell S. Fisher</i> M.D. EXAMINER'S NAME (Type): Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 8-7-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-11-72	
24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Sidney Whorton	
25C. FUNERAL DIRECTOR Kelson F.H.		ADDRESS 1348 Calhoun Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07732	
72 07732 CERTIFICATE OF DEATH				STATE OF MARYLAND-DEM	
BIRTH NO. A-326		1. NAME OF DECEASED (Type or Print) ELLA ADGER		2. DATE AND HOUR OF DEATH 8/9/72 4 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIV. OF MARYLAND HOSPITAL 38			A. STATE MD. B. COUNTY 1403		
C. CITY OR TOWN BALTIMORE			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 580 BAKER ST.					
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/16/22	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Mtn.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Neal Harvey same	
18. 493X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST		
ANTECEDENT CAUSES			(B) BRONCHIAL ASTHMA YEARS		
			(C) ASCVD PULMONARY ASPIRATION YEARS 10 min		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			ASCVD		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 8/9 1972 to 8/9 1972, that (we) lost saw the deceased alive on 8/9 1972 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.					
23A. SIGNATURE [Signature] MD				23B. DATE SIGNED 8/10/72	
23C. PHYSICIAN'S NAME (Type) [Signature]				23D. ADDRESS UNIV. OF MARYLAND HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-14-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. FUNERAL DIRECTOR V. Bailey		24F. ADDRESS 1348 Calhoun Street	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR [Signature]	

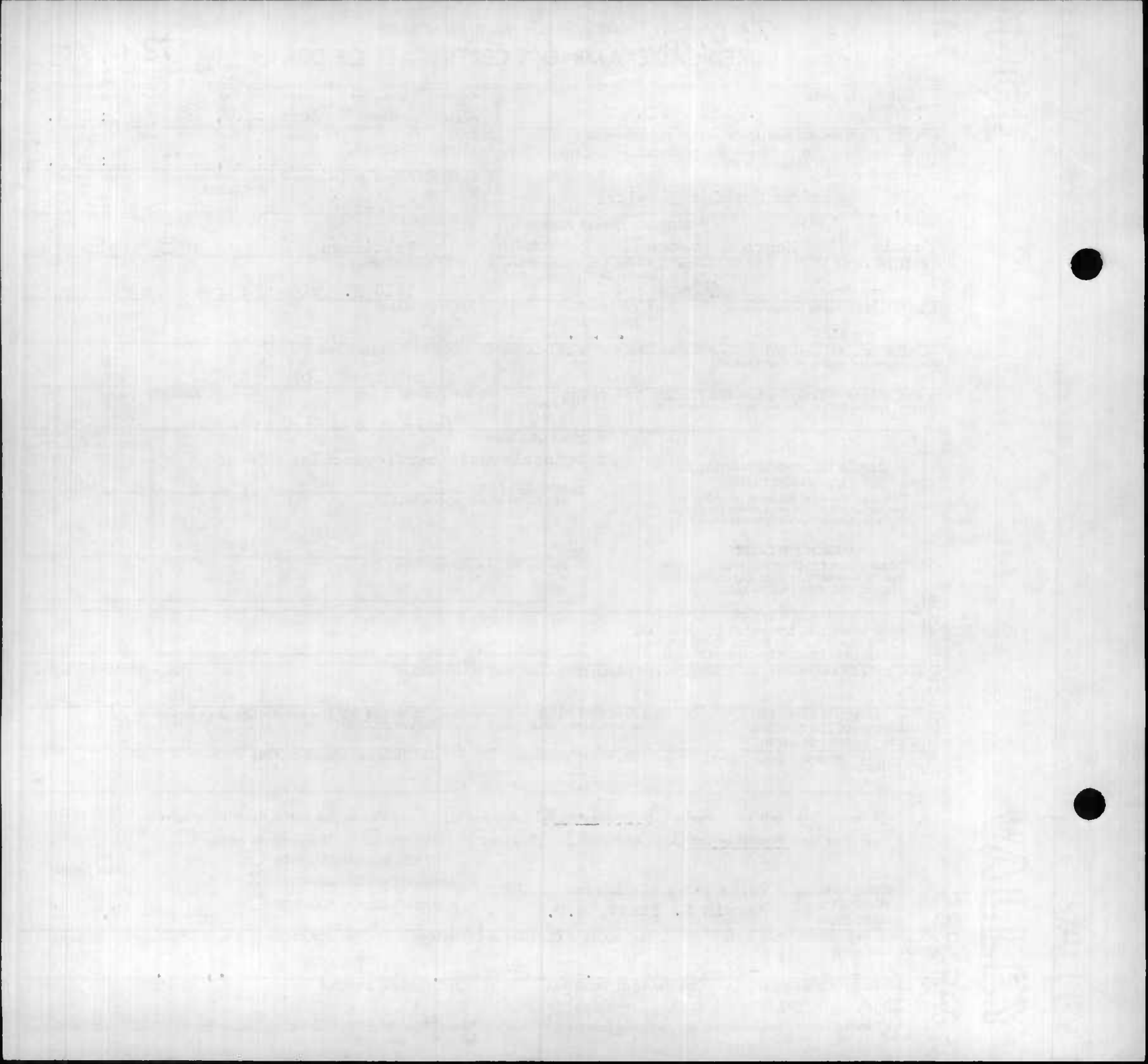


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JANIE WILSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour August 10, 1972 5:05 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour August 10, 1972 5:05 A. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY 1501	
9. DATE OF BIRTH 4-30-01		10. AGE (in years lost birthday) 71	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 218101712	
18. INFORMANT Daniel Smothers		ADDRESS 428 Watty Court	
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 0		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 10, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-14-72	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Sidney J. Weston	
25C. FUNERAL DIRECTOR Kelson E.H.		ADDRESS 1348 Calhoun Street	

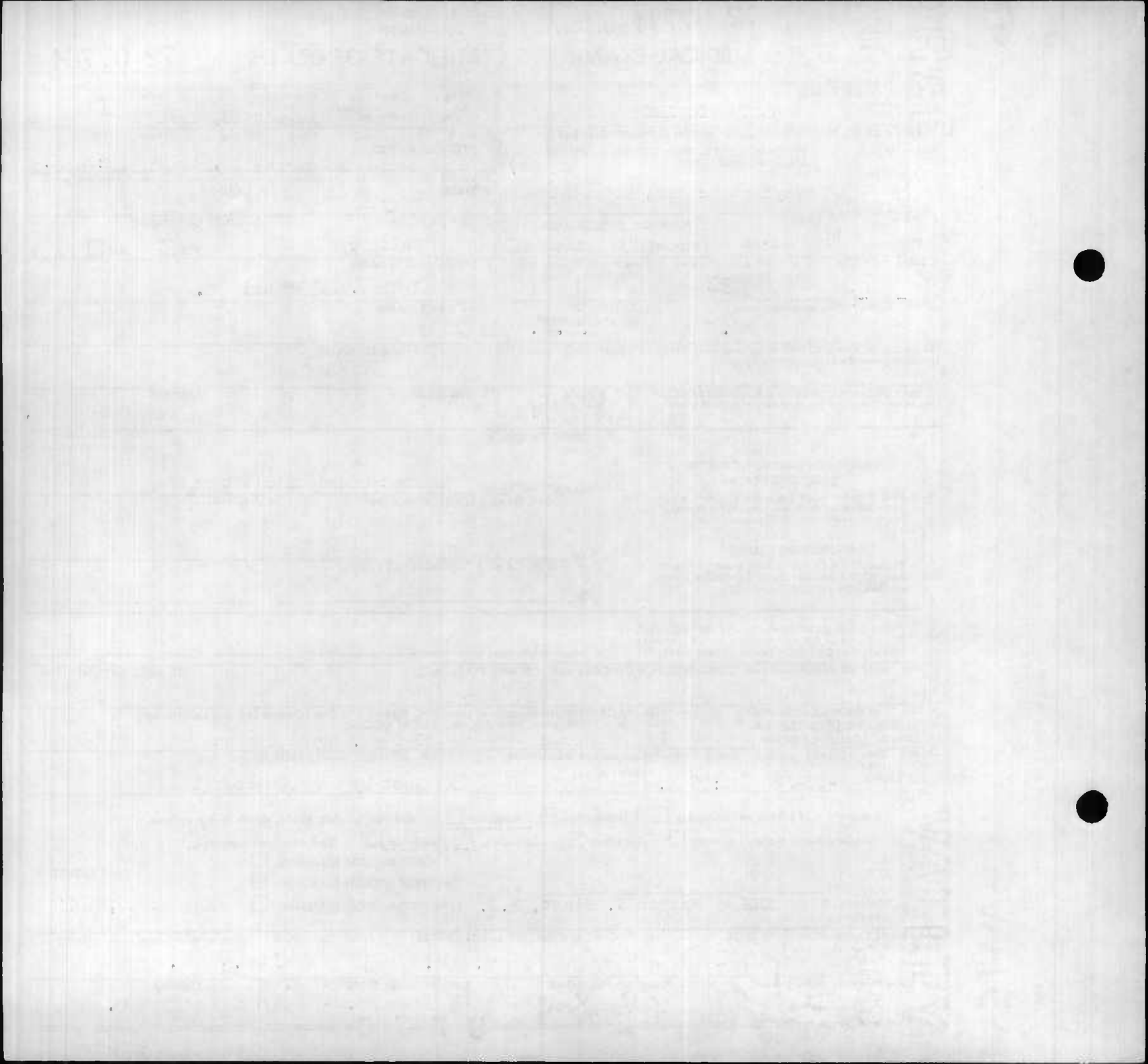


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07734

BIRTH NO.

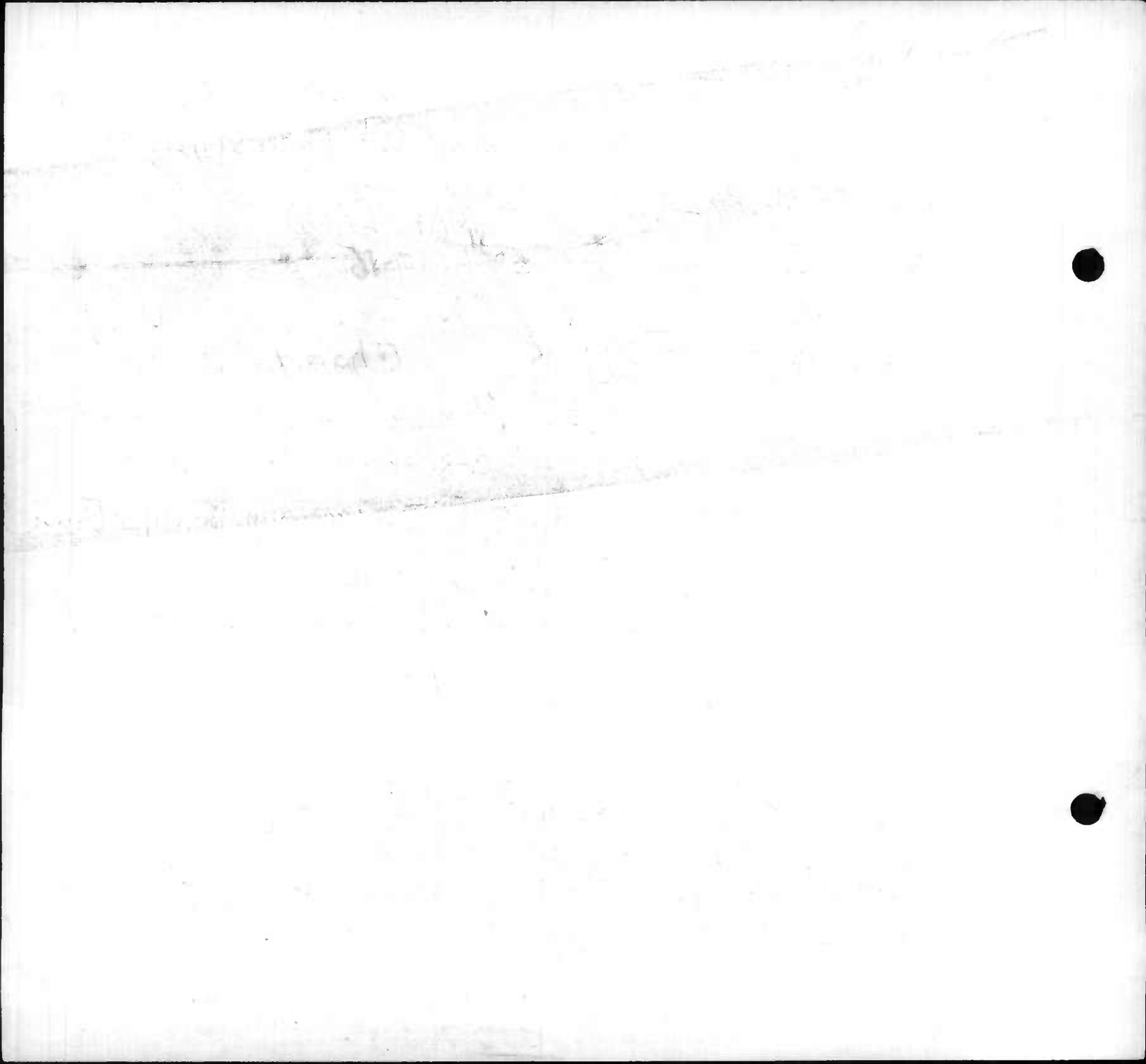
1. NAME OF DECEASED (Type or Print) LLOYD WIGGINS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 10, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) (DOA) Maryland General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour August 10, 1972 2:30 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1503	
9. DATE OF BIRTH 12-22-38		10. AGE (In years last birthday) 32 33 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 219281118	
18. INFORMANT Normilee Cofield		ADDRESS 1606 Smallwood St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 8-10-72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2306 Mt. Royal Terrace		22D. TIME OF INJURY (APPROX.) 8-10-72 2:05 A.M.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot by unknown assailant	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Marvin S. Platt, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 10, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-14-72	
24C. NAME of CEMETERY or CREMATORY Carver Mem. Pk.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Sidney Anthon	
25C. FUNERAL DIRECTOR Kelson F.H.		ADDRESS 1348 Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-200		72 07735		BALTIMORE CITY HEALTH DEPARTMENT		72 07735	
BIRTH NO.		72 07735		REG. NO.		72 07735	
1. NAME OF DECEASED (Type or Print) DANIEL T. FOGG				2. DATE AND HOUR OF DEATH 8/10/72 9:15 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIV. OF MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO. C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 508 Mt. Holly St. # 2037			
5. SEX M	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-19-16	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) N. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Plummer Fogg				14. MOTHER'S MAIDEN NAME Charity Hughes			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220105950		17. INFORMANT Medical Record Univ. of Md. Hosp			
18. 11241 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIO PULMONARY ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Postp. Bronchial leakage, Empyema				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Postp. Bronchial leakage, Empyema							
19A. DATE OF OPERATION 8/21/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Mycetoma		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-10-72 to 8-10-72 that (I) (we) last saw the deceased alive on 8-10-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Clement C. Ugorski MD				23B. DATE SIGNED 8/10/72			
23C. PHYSICIAN'S NAME (Type) CLEMENT C. UGORSKI				23D. ADDRESS UNIV. OF MD. HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-15-72		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Sidney J. Foster		25C. FUNERAL DIRECTOR V. Bailey		ADDRESS 1348 Calhoun Street	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07736

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RANELL SCOTT		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour August 9, 1972 11:14 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour August 9, 1972 11:14 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2542			
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. CITY OR TOWN Baltimore
10. AGE (In years last birthday) 9/3/69 2½		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY U.S.		13. FATHER'S NAME James Lee Scott	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N.A.		15. MOTHER'S MAIDEN NAME Bertha Anell Welche	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) N.A.		17. SOCIAL SECURITY NO. N.A.	
18. INFORMANT Bertha Anell Scott		ADDRESS 2803 Seaman Ave.	
19. 323 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Mild encephalitis of unknown etiology ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II 20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) Yes		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Marvin S. Platt</i> M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 10, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/12/72	24C. NAME of CEMETERY or CREMATORY Union Cypus	24D. LOCATION (City, town, or county) (State) Manning, South Carolina
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972	25B. NAME OF REGISTRAR <i>Sidney Johnson</i>	25C. FUNERAL DIRECTOR Charles A. Rice 1300 Eutaw Place	

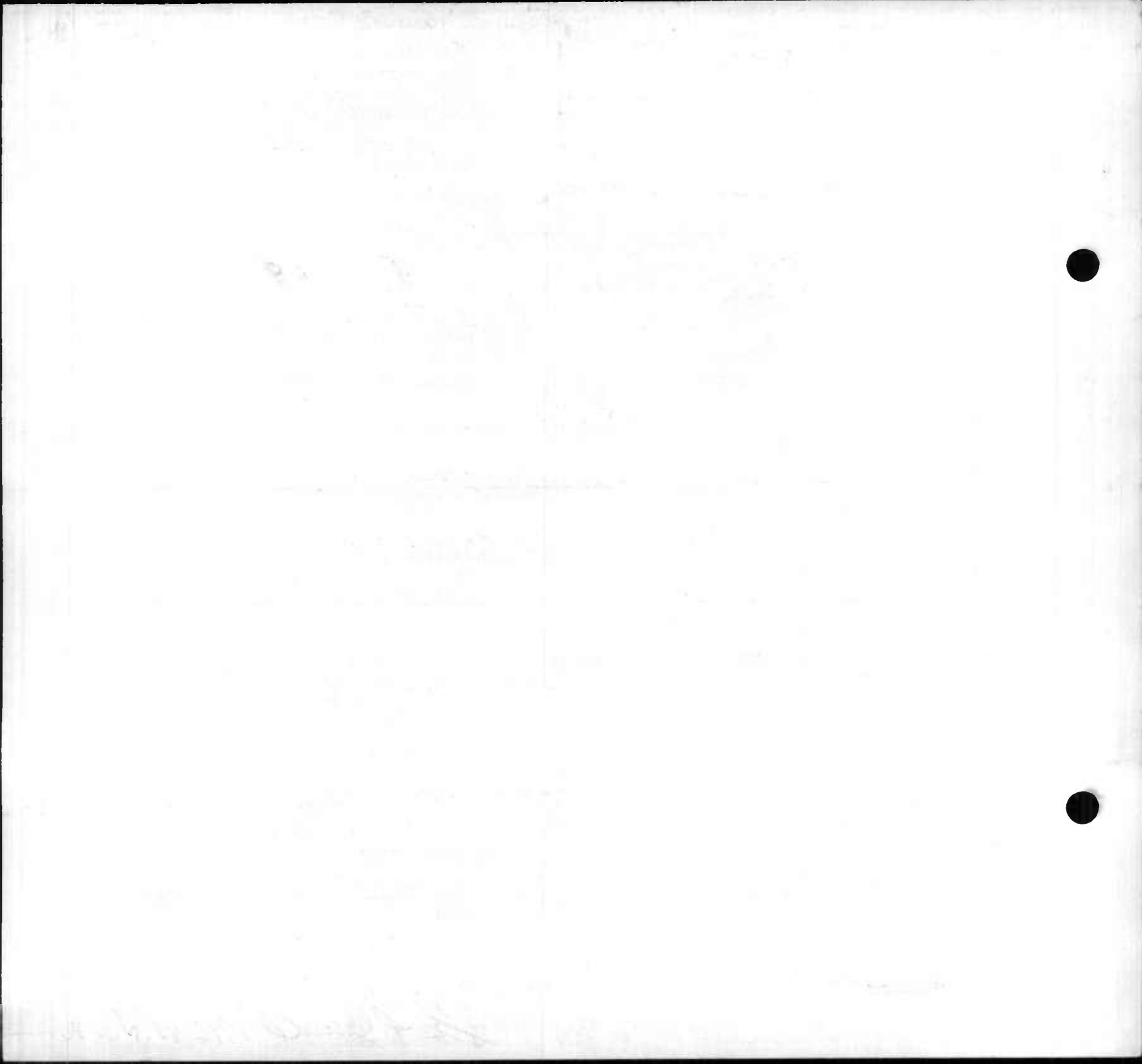
10/3/72 - Letter from M.E.O.

Be.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		72 07737		REG. NO.		72 07737	
1. NAME OF DECEASED (Type or Print)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		5. DATE AND HOUR OF DEATH		STATE OF MARYLAND-DHMH	
SIMPSON THOMAS		UNIV. OF MD. HOSPITAL		BALTO MD 1801		7/28/72 355 P M.			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
UNIV. OF MD. HOSPITAL		NEGRO				4/1/07		65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY			
				South Carolina		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
						214-18-2573		CHART	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		CARDIOPULMONARY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		CARDIO MYOPATHY			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last				(C)					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
7/28		INSERTION OF TRANSVENOUS PACEMAKER							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (1) (this hospital) attended the deceased from 7/28 19 72 to 7/28 19 72		that (1) (we) last saw the deceased alive on 7/28 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
A. A. Fleming MD		7/28/72		A. A. Fleming MD		UNIV. OF MD HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		8/3/72		Mt. Calvary		A.A. County, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
AUG 14 1972		Sidney Thornton		252 P. Small		1712 W. North Ave			



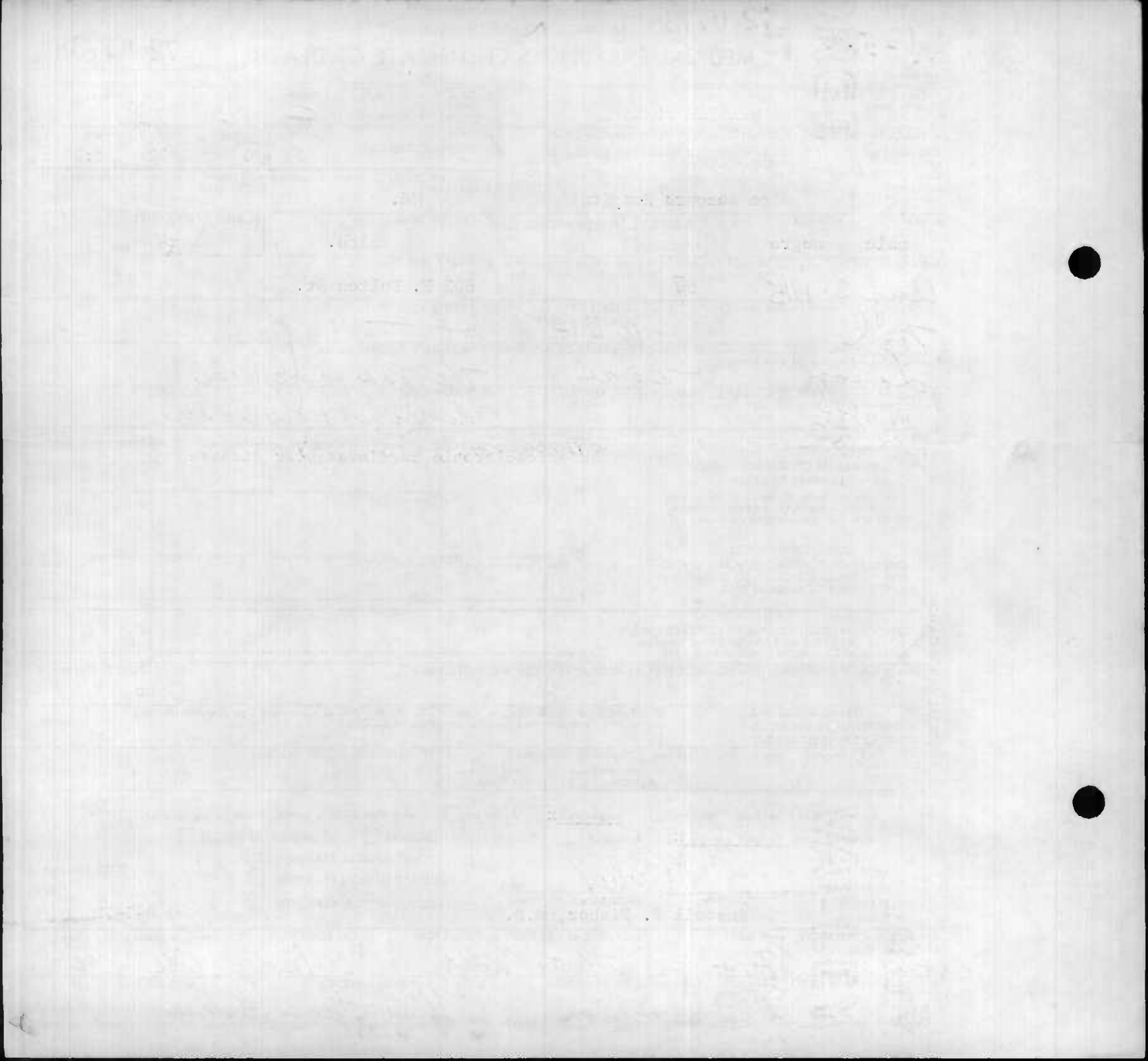
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07738

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM JONES		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> 8 6 1972 Hour 8:20 a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 6 1972 8:20 a M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Aug 5 - 1915		10. AGE (in years lost birthday) 57	
11. BIRTHPLACE (State or foreign country) md		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		14B. KIND OF BUSINESS OR INDUSTRY none	
15. MOTHER'S MAIDEN NAME Verion Hanson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no (unknown)) (If yes, give war or dates of service) WASH	
17. SOCIAL SECURITY NO.		18. INFORMANT Verion Hanson	
19. 4-12-71 CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-7-72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-12-72	
24C. NAME OF CEMETERY or CREMATORY Pulaski Chapel		24D. LOCATION (City, town, or county) (State) Whaleyville md	
25A. DATE REC'D BY HEALTH DEPT. AUG 14 1972		25B. NAME OF REGISTRAR Lidney Johnston	
25C. FUNERAL DIRECTOR West Sun Home		ADDRESS	



K-300

72 07739 STATE OF MARYLAND-DEPT
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07739

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Harold Kite				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1117 Ensor Street				3. DATE PRONOUNCED DEAD Month Day Year Hour 7 22 72 1:45 p. M.			
6. SEX male				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years lost birthday) 75		11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? UNKNOWN	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN				14B. KIND OF BUSINESS OR INDUSTRY UNKNOWN		15. MOTHER'S MAIDEN NAME UNKNOWN	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN				17. SOCIAL SECURITY NO. UNKNOWN		18. INFORMANT ADDRESS UNKNOWN	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) NO	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Marvin Platt</u> M.D. EXAMINER'S NAME (Type) Marvin Platt, M.D. DATE SIGNED 7/23/72							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8/14/72		24C. NAME OF CEMETERY or CREMATORY Anatomy Bd.		24D. LOCATION (City, town or county) (State) ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972		25B. NAME OF REGISTRAR Sidney Whitton		25C. FUNERAL DIRECTOR C. Carson		ADDRESS	

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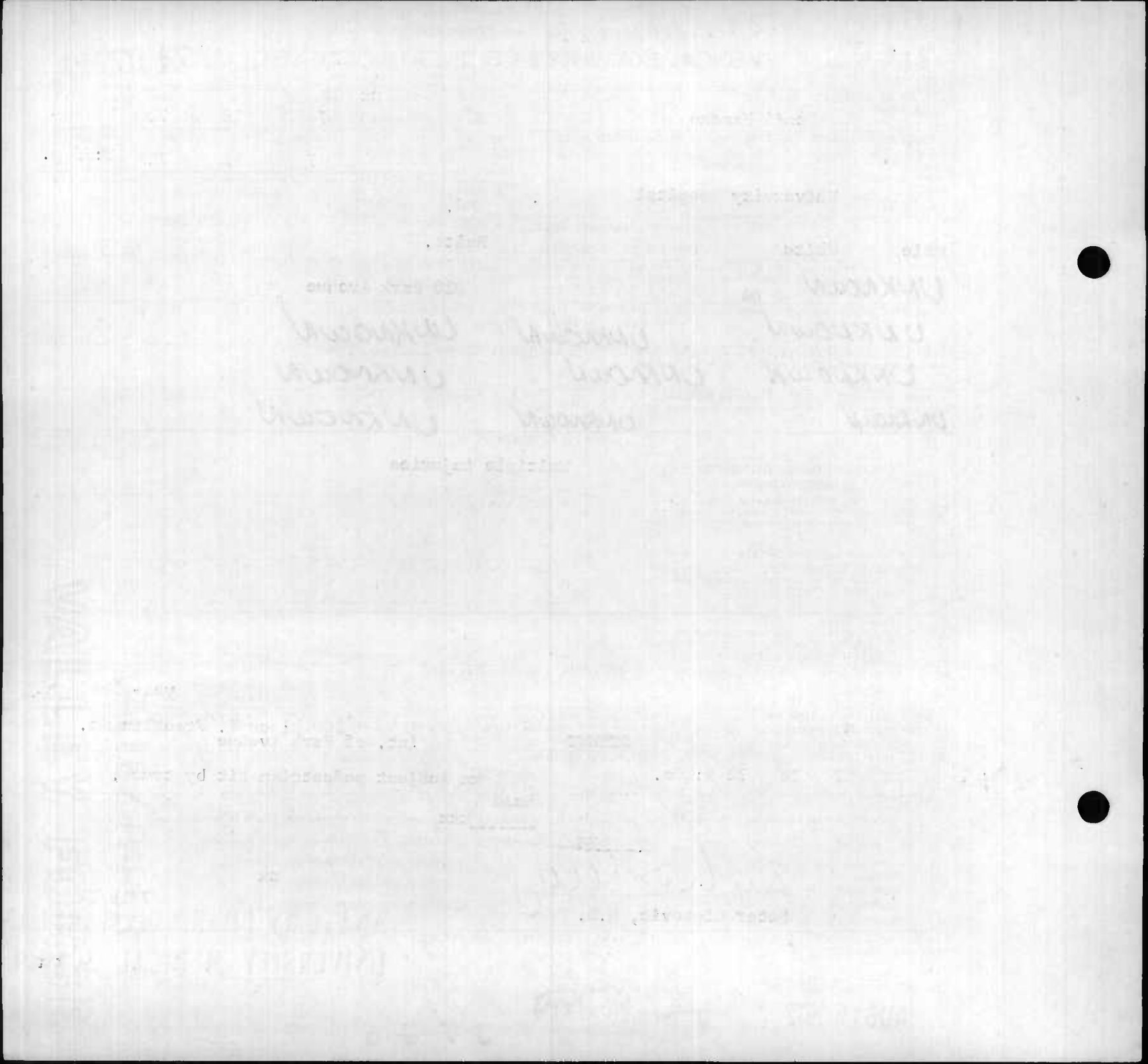
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07740

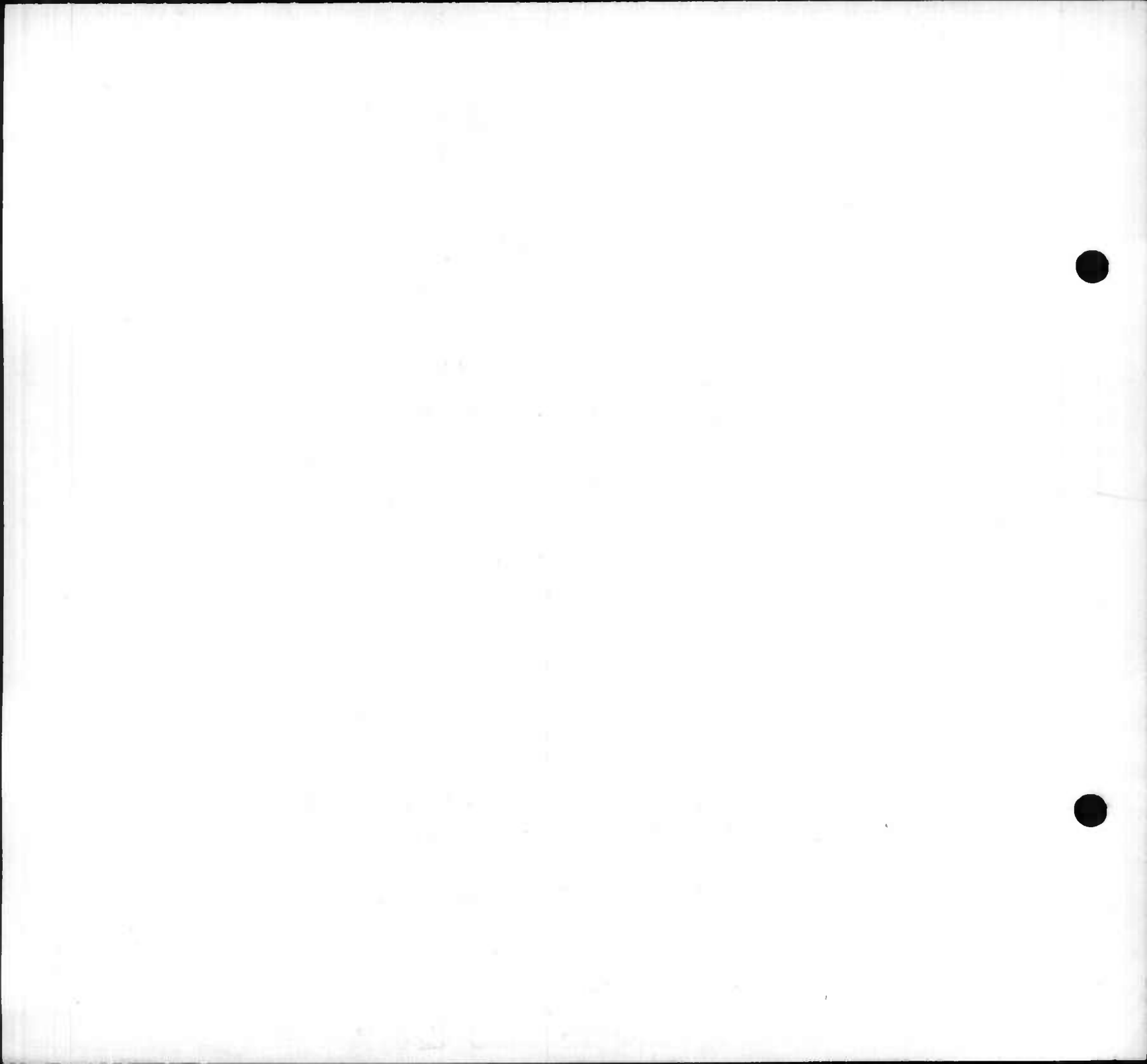
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Denji Hamano		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 18 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 18 72 12:55 p. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1102		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. SEX male	7. RACE White	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH UNKNOWN		10. AGE (In years lost birthday) 84 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? UNKNOWN	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		14B. KIND OF BUSINESS OR INDUSTRY UNKNOWN	
15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN	
17. SOCIAL SECURITY NO. UNKNOWN		18. INFORMANT ADDRESS UNKNOWN	
19. CAUSE OF DEATH 28147 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Multiple injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 8/1/72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes- head only			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 200 block W. Franklin St. int. of Park Avenue		22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) 7 18 72 9:20a.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> head		22F. HOW DID INJURY OCCUR? Subject pedestrian hit by truck.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/19/72			
24A. BURIAL CREMATION, REMOVAL (Specify) 8/1/72		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY Anatomy Bd.		24D. LOCATION (City, town, or county) (State) ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972		25B. NAME OF REGISTRAR Aidy Ingham	
25C. FUNERAL DIRECTOR Curran		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-652		72 07741		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 27207741	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ALFRED FRANKS				2. DATE AND HOUR OF DEATH 8/9/72 12 30			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BOLTON HILL NURSING HOME LAFAYETTE & JOHN STREET				A. STATE MARYLAND B. COUNTY 1402			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1406 MADISON AVENUE				APTIC. 21217			
5. SEX MALE	6. RACE BLACK	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-3-99	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN UNKNOWN				16. SOCIAL SECURITY NO. 098-03-7311		17. INFORMANT ADMISSION RECORD	
18. CAUSE OF DEATH 71221				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) middle cerebral artery thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6/72	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: hypertensive C.V. disease		(B) yes	
				(C) arteriosclerosis generalized		(C) yes	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 8/10/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/18 19 72 to 8/9 19 72 that (I) (we) last saw the deceased alive on 8/9 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. M. A. [Signature]				23B. DATE SIGNED 8/10/72		23C. PHYSICIAN'S NAME (Type) Dr. M. A. [Signature]	
23D. ADDRESS 2 E. [Signature]				23E. NAME OF CEMETERY or CREMATORY Anatomy Bd.		23F. LOCATION (City, town or county) (State) ANATOMY BOARD OF MARYLAND	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 8/10/72		24C. NAME OF CEMETERY or CREMATORY Anatomy Bd.		24D. LOCATION (City, town or county) (State) UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972		25B. NAME OF REGISTRAR Andrew [Signature]		25C. FUNERAL DIRECTOR [Signature]		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 07742 ✓ STATE OF MARYLAND-DEMH
L-200 BIRTH NO. 72-10940		72 07742		
1. NAME OF DECEASED (Type or Print) <i>Baby Girl Lewis</i>		2. DATE AND HOUR OF DEATH <i>August 3, 1972 10:54 p.m. M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Sinai Hospital of Baltimore</i> <i>42</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>Belvedere Ave at Greenspring</i> <i>2944 Shady Ave</i>		
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 29, 1972</i>	9. AGE (In years last birthday) <i>6 days</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>
13. FATHER'S NAME <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Francis Lewis</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>77691</i> CAUSE OF DEATH <i>respiratory arrest and cardiac standstill.</i> ANTECEDENT CAUSES <i>prematurity.</i> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour prior to death.</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>August 1st 1972</i> to <i>August 3 1972</i> that (I) (we) last saw the deceased alive on <i>August 3rd 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Hiroaki Takahashi</i>		23B. DATE SIGNED <i>August 3rd, 1972</i>		23C. PHYSICIAN'S NAME (Type) <i>Hiroaki Takahashi</i>
24A. BURIAL OR CREMATION REMOVAL (Specify)		24B. DATE <i>8/10/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Anatomy Bd</i>
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 15 1972</i>		25B. NAME OF REGISTRAR <i>72 07742</i>		25C. FUNERAL DIRECTOR <i>Couran</i>

2444 Shirley Ave.

CT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>8-455 72 07743 BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>72 07743 REG. NO.</p> <p>STATE OF MARYLAND-DEME</p>	
<p>BIRTH NO. <u>7-10428</u> <u>Baby boy</u> <u>Solomon</u></p>		<p>1. NAME OF DECEASED (Type or Print) <u>BABY BOY Solomon</u></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital of Baltimore Belvedere</u> <u>avenue at green spring 21215</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>BALTIMORE</u> B. COUNTY <u>BALTIMORE</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>3901 Forest PK. Ave #07 1510</u></p>	
<p>5. SEX <u>M</u></p>	<p>6. RACE <u>Black</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>7-20-72</u></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (State or foreign country) <u>Sinai Hospital Baltimore</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u></p>	
<p>13. FATHER'S NAME <u>Isaac Solomon</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Betty Lewis</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>	
<p>17. INFORMANT</p>		<p>ADDRESS</p>	
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> <p>(A) IMMEDIATE CAUSE <u>Severe respiratory distress</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Bleeding from lung</u></p> <p>(B) <u>prematurely respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: <u>systemic</u></p> <p>(C) <u>prematurely</u> <u>prematurely, electrolyte disturbance</u></p>			
<p>19A. DATE OF OPERATION <u>2</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nasty-medical-examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>7-20-72</u> 19 to <u>7-24-72</u> 19</p> <p>that (I) (we) last saw the deceased alive on <u>7-24-</u> 19 72 and that in (my) (our) opinion death occurred on the date</p> <p>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <u>A. SHAHIDEH</u></p>		<p>23B. DATE SIGNED <u>7-24-72</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>A. SHAHIDEH</u></p>		<p>23D. ADDRESS <u>Sinai Hospital of Baltimore</u></p>	
<p>24A. BURIAL CREMATION <u>8/10/72</u></p>		<p>24B. DATE REMOVAL (Specify)</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <u>Anatomy Bd</u></p>		<p>24D. LOCATION (City, town, or county) <u>UNIVERSITY MEDICAL SCHOOL</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1972</u></p>		<p>25B. NAME OF REGISTRAR <u>Andrew Wharton</u></p>	
<p>25C. FUNERAL DIRECTOR <u>3 Quinn</u></p>		<p>ADDRESS</p>	

At time of birth + death Mother's address was

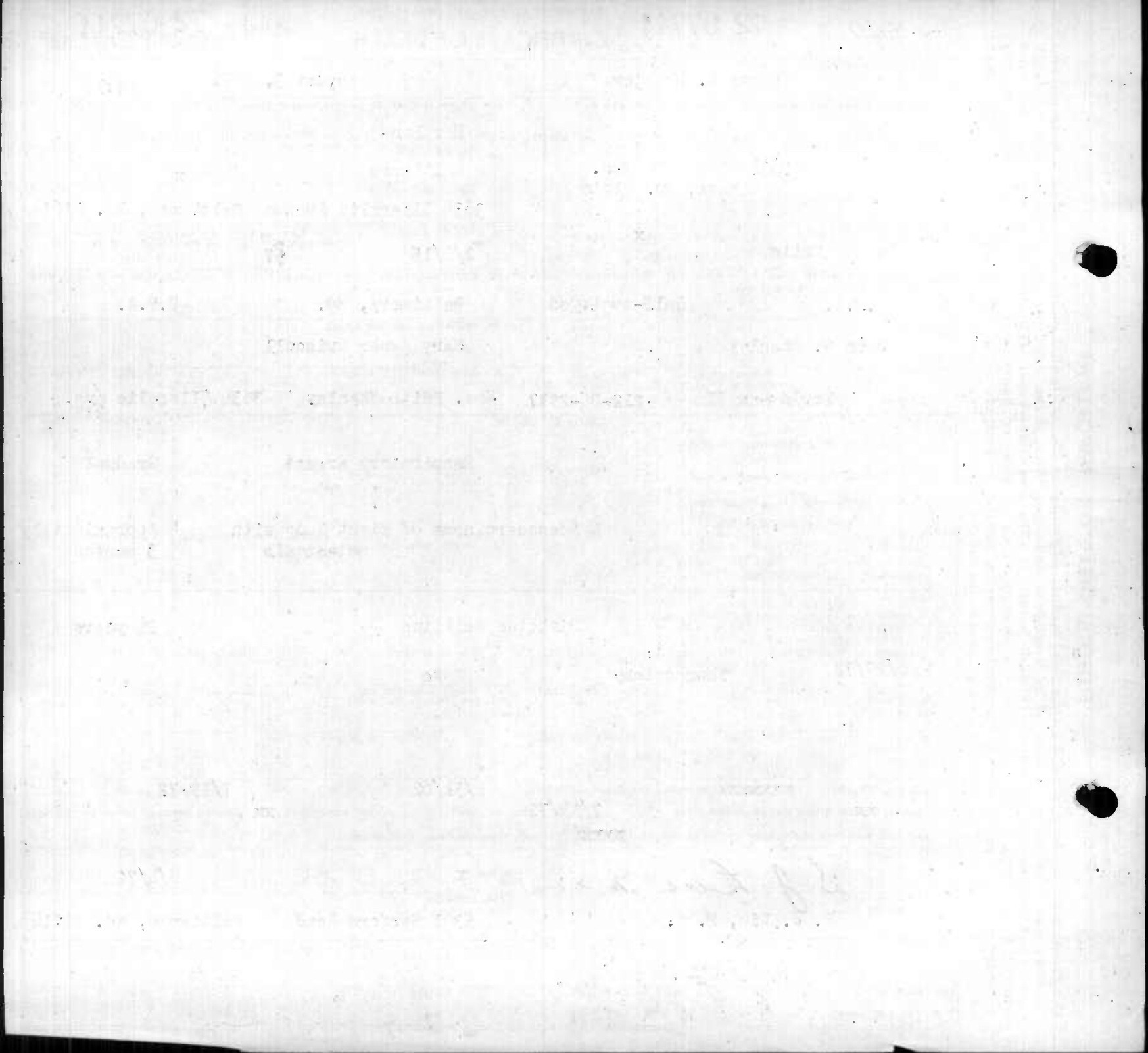
4025 Boardman Ave

Census Tract 1510

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

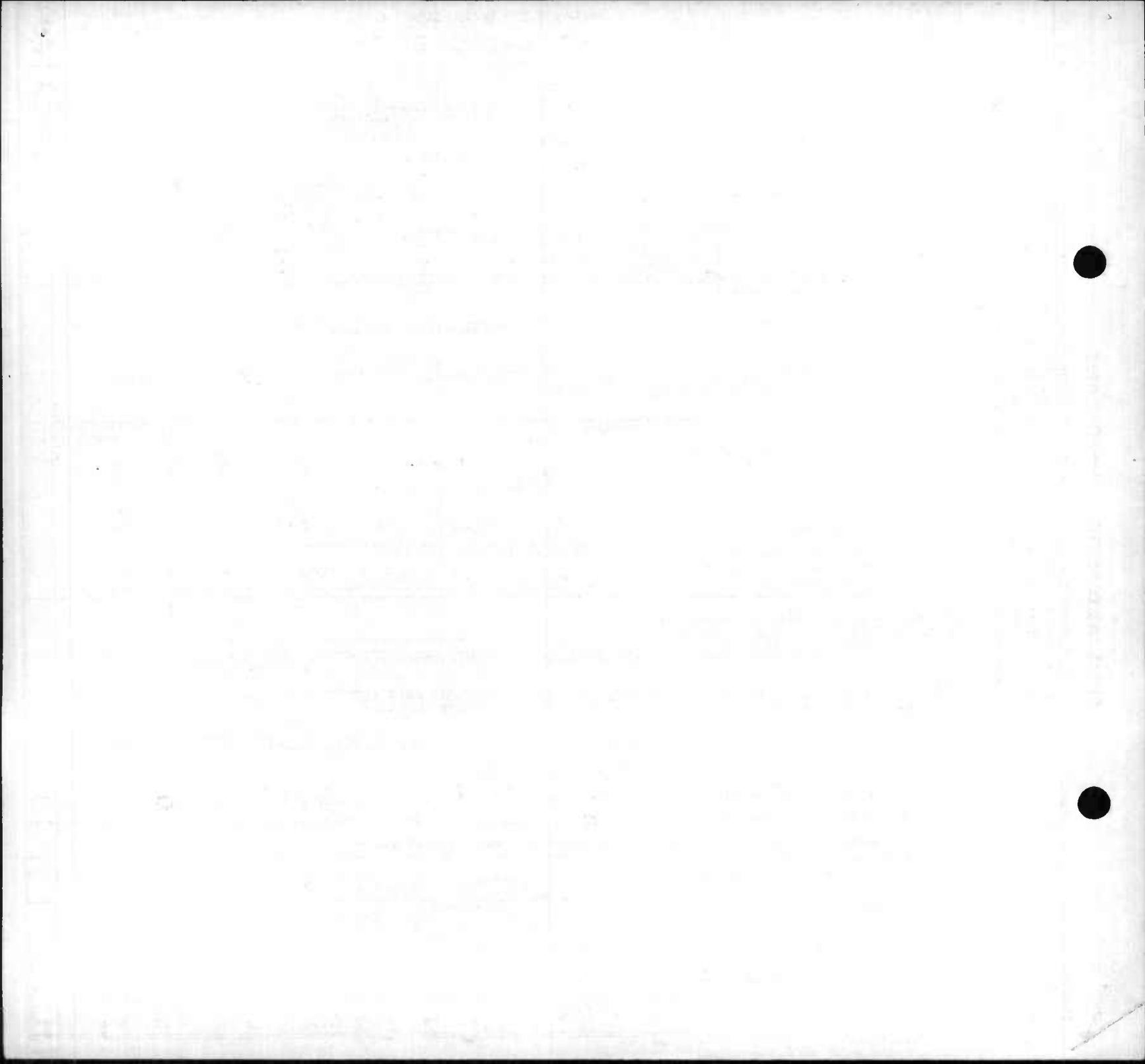
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07744	
S-540 72 07744				STATE OF MARYLAND - DHMH	
BIRTH NO.				DECEASED	
1. NAME OF DECEASED (Type or Print) Thomas A. Shanley			2. DATE AND HOUR OF DEATH August 3, 1972 7:15 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3634 Ellerslie Ave. Baltimore, Md. 21218			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 903		
5. SEX Male			6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 2/6/15		9. AGE (In years last birthday) 57		10. If Under 1 Tr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C.P.A.			10B. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John T. Shanley		
14. MOTHER'S MAIDEN NAME Mary Agnes Driscoll			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II		
16. SOCIAL SECURITY NO. 212-05-2917		17. INFORMANT ADDRESS Mrs. Edith Shanley 3634 Ellerslie Ave. 21218			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory arrest			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Gradual		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Adenocarcinoma of right lung with metastasis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Approximately 3 months		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes mellitus			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years		
21A. DATE OF OPERATION 6/29/72		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED Thoracotomy		21C. AUTOPSY? (Yes or No) No	
21D. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21G. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21H. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21I. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 5/31/62 19 to 7/19/72 19, that (I) (the hospital) last saw the deceased alive on 7/19/72 19 and that in (my) (the hospital) opinion death occurred on the date and hour and from the causes stated above. (I) (the hospital) (did not) view the body after death.					
23A. SIGNATURE S. J. Liu M.D.				23B. DATE SIGNED 8/4/72	
23C. PHYSICIAN'S NAME (Type) S. J. Liu, M. D.				23D. ADDRESS 5301 Harford Road Baltimore, Md. 21214	
24A. BURIAL CREMATION, REMOVAL (Specify) P-10-72		24B. DATE 8-10-72		24C. NAME of CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972		25B. NAME OF REGISTRAR Sidney A. [Signature]		25C. FUNERAL DIRECTOR 37 [Signature]	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07745		72 07745	
V-240				72 07745		72 07745	
1. NAME OF DECEASED (Type or Print) RICHARD YOKEL				2. DATE AND HOUR OF DEATH 7-29-72 5:52 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital				A. STATE Maryland B. COUNTY 1510			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2600 Liberty Heights Ave.				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male				6. RACE B		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 11/10 9. AGE (in years last birthday) 71	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 7-10-72 I				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio Respiratory Arrest minutes			
				(B) Coronary Thrombosis days			
				(C) Arteriosclerotic Heart Disease years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-21-72 19 10 to 7-28-72 19 12 that (I) (we) last saw the deceased alive on 7-28-72 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Janet V. Maphis, MD				23B. DATE SIGNED 7-29-72		23C. PHYSICIAN'S NAME (Type)	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE 8-10-72		24C. NAME OF CEMETERY or CREMATORY	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR 37 Cuman	
25D. LOCATION (City, town, or county)				25E. ADDRESS		ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 07746</u>	
K-641 72 07746				STATE OF MARYLAND-DEMET	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>KARALFA, MARY E.</u>				2. DATE AND HOUR OF DEATH <u>AUG. 9, 1972</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 House-in-the-Pines, Belvedere</u>				A. STATE <u>Md.</u> 8. COUNTY <u>908</u>	
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				E. STREET AND NUMBER <u>2911 Oak Hill Avenue</u>	
10B. KIND OF BUSINESS OR INDUSTRY				8. DATE OF BIRTH <u>5/30/93</u> 9. AGE (In years last birthday) <u>79 yrs.</u>	
13. FATHER'S NAME <u>Andrew Doyle</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
16. SOCIAL SECURITY NO.				14. MOTHER'S MAIDEN NAME <u>Carr</u>	
17. INFORMANT <u>Robt. J. Karalfa, 2911 Oak Hill Avenue, 21207</u>				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>CEREBROVASCULAR THROMBOSIS</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 WEEKS</u>	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(B) <u>CEREBRAL ARTERIOSCLEROSIS</u>				<u>5 YEARS</u>	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>PERNICIOUS ANEMIA</u>				<u>5 YEARS</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>AUG 7, 1967</u> to <u>AUG 9, 1972</u> that (I) (we) last saw the deceased alive on <u>AUG. 9, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Marvin Goldstein, M.D.</u>				23B. DATE SIGNED <u>AUG. 10, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>MARVIN GOLDSTEIN, M.D.</u>				23D. ADDRESS <u>6001 PARK HIGHTS. AVE. BALTO. MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-14-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore Nat'l. Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1972</u>		25B. NAME OF REGISTRAR <u>Sidney [Signature]</u>		25C. FUNERAL DIRECTOR <u>Armocost Funeral Chapel, 4600 Lib. Hts.</u>	
				ADDRESS	

2

CONFIDENTIAL - INTERNAL SECURITY

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/1/80 BY SP-5 JRS/STW

EXCEPT WHERE SHOWN OTHERWISE

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DATE 10/1/80 BY SP-5 JRS/STW

EXCEPT WHERE SHOWN OTHERWISE

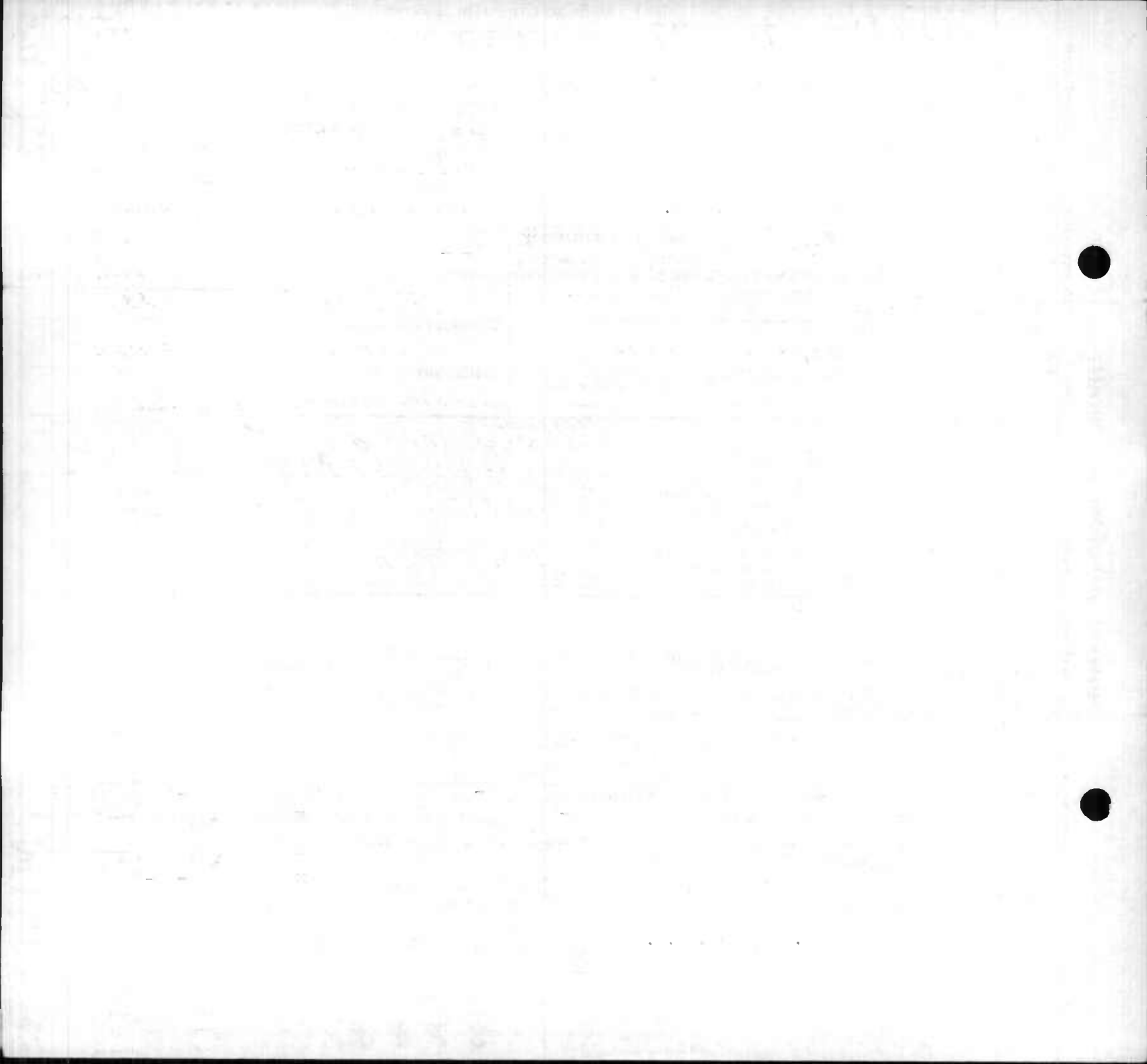
CONFIDENTIAL - INTERNAL SECURITY

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-600		72 07747		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07747	
BIRTH NO.				STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print) O'Hara Sister Catherine				2. DATE AND HOUR OF DEATH 8/10/72 10:10 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital, Inc.				A. STATE MD.		B. COUNTY BALTO.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN STEVENSON		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER VALLEY RD. - NOTRE DAME INFIRMARY			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-7-08	9. AGE (in years last birthday) 64	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious			11. BIRTHPLACE (State or foreign country) IRELAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME EDWARD O'HARA			14. MOTHER'S MAIDEN NAME CATHERINE FINAN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Sister Margaret - Valley Rd. Stevenson		
18. 016101 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Oseptemia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Probable Tbc - R. Kidney (B) DUE TO, OR AS A CONSEQUENCE OF: Probable Tbc - Spine (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 3 mo. 3 mo.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 8-10 19 72 to 8-10 19 72 that (I) (we) last saw the deceased alive on 8-10 19 72 and that in (J) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Terry P. Detrich, M.D.						23B. DATE SIGNED 8-11-72	
23C. PHYSICIAN'S NAME (Type) Terry P. Detrich, M.D.				23D. ADDRESS Mercy Hospital			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-12-72		24C. NAME OF CEMETERY OR CREMATORY Trinity Cemetery		24D. LOCATION (City, town, or county) (State) Stechester Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972		25B. NAME OF REGISTRAR Friday Johnson		25C. FUNERAL DIRECTOR Jolly Grombaugh		ADDRESS Catonville, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 07748</u>	
L-362 72 07748				STATE OF MARYLAND-DEATH	
BIRTH NO. <u>L-362</u>		1. NAME OF DECEASED (Type or Print) <u>LETRISE, PAUL J</u>		2. DATE AND HOUR OF DEATH <u>8/12/72</u> <u>10 PM.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>VETERANS ADMINISTRATION HOSPITAL</u> <u>3900 LOCH RAVEN BLVD</u> <u>BALTIMORE, MARYLAND 21218</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>27 BISHOP LANE</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2/9/34</u>	9. AGE (In years last birthday) <u>38</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRAFTSMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>WESTINGHOUSE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOSEPH LETRISE</u>		14. MOTHER'S MAIDEN NAME <u>MYRTLE GRIPP</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>5-9-51 to 1-4-55</u>		16. SOCIAL SECURITY NO. <u>219-30-75-76</u>		17. INFORMANT ADDRESS <u>CLINICAL RECORDS-VAH BALTIMORE, MARYLAND</u>	
18. <u>431.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> <u>CEREBRAL HEMMORAGE</u> <u>72 hrs</u> <u>ANTECEDENT CAUSES</u> <u>HYPERTENSION</u> <u>9 yrs</u> <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>8-10-1972</u> to <u>8-12-1972</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>8-12-1972</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (do not) view the body after death.					
23A. SIGNATURE <u>K. Margolis</u>		23B. DATE SIGNED <u>8/12/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>K. MARGOLIS MD</u>		23D. ADDRESS <u>VA HOSPITAL BALTIMORE, MARYLAND 21218</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-16-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1972</u>		24F. NAME OF REGISTRAR <u>Henry Wharton</u>	
24G. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1972</u>		24H. NAME OF REGISTRAR <u>Henry Wharton</u>		24I. FUNERAL DIRECTOR ADDRESS <u>Forley Capraugh & Co.</u>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-622		72 07749	
BIRTH NO. 11-07-172 07749		CERTIFICATE OF DEATH	
1. NAME OF DECEASED <i>BRASKIS, Dorothy A</i>		2. DATE AND HOUR OF DEATH <i>8/7/72</i> A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 The Johns Hopkins Hospital</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Female</i> 6. RACE <i>Cauc.</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11/7/17</i> 9. AGE (In years last birthday) <i>54</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Joseph Bubnis</i>		14. MOTHER'S MAIDEN NAME <i>Anna Cawrowski</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-10-7019</i>	
17. INFORMANT (Husband) <i>Dundalk, Md.</i> ADDRESS <i>Mr. Walter W. Braskis, 6730 Railway Ave.</i>			
18. <i>174X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>? Pulmonary embolus</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Postoperative cancer metastasis</i>	
		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Breast carcinoma C-Pang (L) 4 mo.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <i>4/72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>cerebello-pontine angle tumor</i>	
20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <i>NA</i>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>N.A.</i>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>N.A.</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <i>N.A.</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>7/1</i> 19 <i>72</i> to <i>8/7</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>8/6</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Frederick Sklar</i>		23B. DATE SIGNED <i>8/7/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>Frederick Sklar, M.D.</i>		23D. ADDRESS <i>The Johns Hopkins Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/10/72</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>John J. Duda</i>	
25C. FUNERAL DIRECTOR <i>John J. Duda</i>		ADDRESS <i>7922 Wise Ave. Dundalk, Md.</i>	

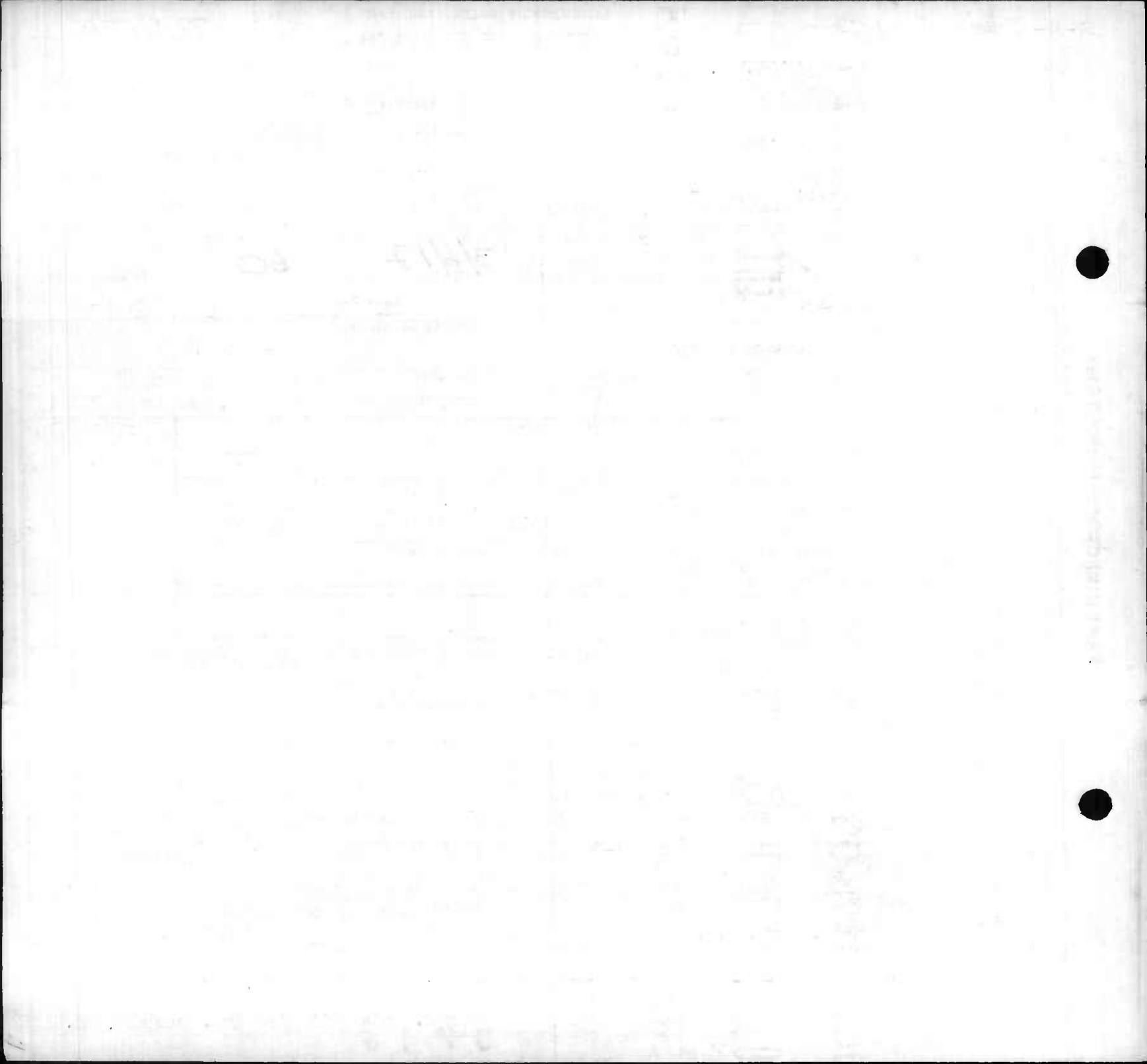
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CITY HEALTH DEPARTMENT		REG. NO. 72 07750	
BIRTH NO. 72 07750				STATE OF MARYLAND		72 07750	
1. NAME OF DECEASED (Type or Print) MILDRED JACOBS				2. DATE AND HOUR OF DEATH 8/6/72 19:45 P			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Balt City Hosp				A. STATE Maryland		B. COUNTY Baltimore	
4940 Eastern Avenue Baltimore, Maryland				C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female 6. RACE Caucasian 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 3/6/12		9. AGE (In years last birthday) 60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Ketchum				14. MOTHER'S MAIDEN NAME Rose Hoone			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. ?		17. INFORMANT 4940 Eastern Avenue	
				BCH: RECORDS Baltimore, Maryland		21224	
18. 277X I				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Lat. myocardial infarction		several hours	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) decreased cholesterol, presumed coronary atherosclerosis		20 to 40 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		None	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/6/72 19 to 8/6/72 19 that (I) (we) last saw the deceased alive on had a pulse for 5 minutes and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. Cardiorespiratory arrest on arrival							
23A. SIGNATURE John W. Kirk, M.D.				23B. DATE SIGNED 8/6/72			
23C. PHYSICIAN'S NAME (Type) John W. Kirk, M.D.				23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-10-72		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR ADDRESS 7922 Wise Ave. Dundalk, Md. 21222			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07751

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CARRIE CRUMP		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 4631 Coleherne Road		3. DATE PRONOUNCED DEAD Month Day Year Hour August 6, 1972 9:50 A. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Pa. B. COUNTY V35	
9. DATE OF BIRTH		10. AGE (In years last birthday) 49	
11. BIRTHPLACE (State or foreign country) Victoria Va		12. CITIZEN OF USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		15. MOTHER'S MAIDEN NAME Nettie Dickinson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Ruth Johnson		ADDRESS 109 W. Lee Street	
19. 4/2/41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/6/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-12-72	
24C. NAME OF CEMETERY or CREMATORY Mount Calvary		24D. LOCATION (City, town, or county) (State) A.A.Co., Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972		25B. NAME OF REGISTRAR Isaiah L. Brown & Son	
25C. FUNERAL DIRECTOR Isaiah L. Brown & Son		ADDRESS 123 W. Montgomery Street	

22/11/11

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

110 47 73
TORRENCE, JAMES

T-652		72 07752		BALTIMORE CITY HEALTH DEPARTMENT		72 07752	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND-DEPT			
James Torrence		8/13/72		2:15 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		1607			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY		C. CITY OR TOWN	
33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		MARYLAND		BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
MALE		NEGRO		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		05-17-07	
9. AGE (In years last birthday)		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
64		64		N.C.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
James Torrence		LULA TORRENCE		No			
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
213-07-6438		Helen L Torrence, 2901 Brighton St. 21216		18. CAUSE OF DEATH			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		20. IMMEDIATE CAUSE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:		Recent cardiac arrest			
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:		Chronic renal failure			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Recent cardiac arrest			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 7/72 to 8/13 1972 and that (I) (we) lost saw the deceased alive on 8/13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
J K Brown MD		8/13/72		JAMES K. BROWN M.D.		THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-17-72		Balto. National Memorial		Laurel, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 15 1972		Kenneth Law		4611 Park Heights Ave.		VS 150-REV. 1/1/68	

200 BELMONT STREET

BA

02-17-02

X

RECORD

LULA TORRENC

5-7-02-04-05

YES

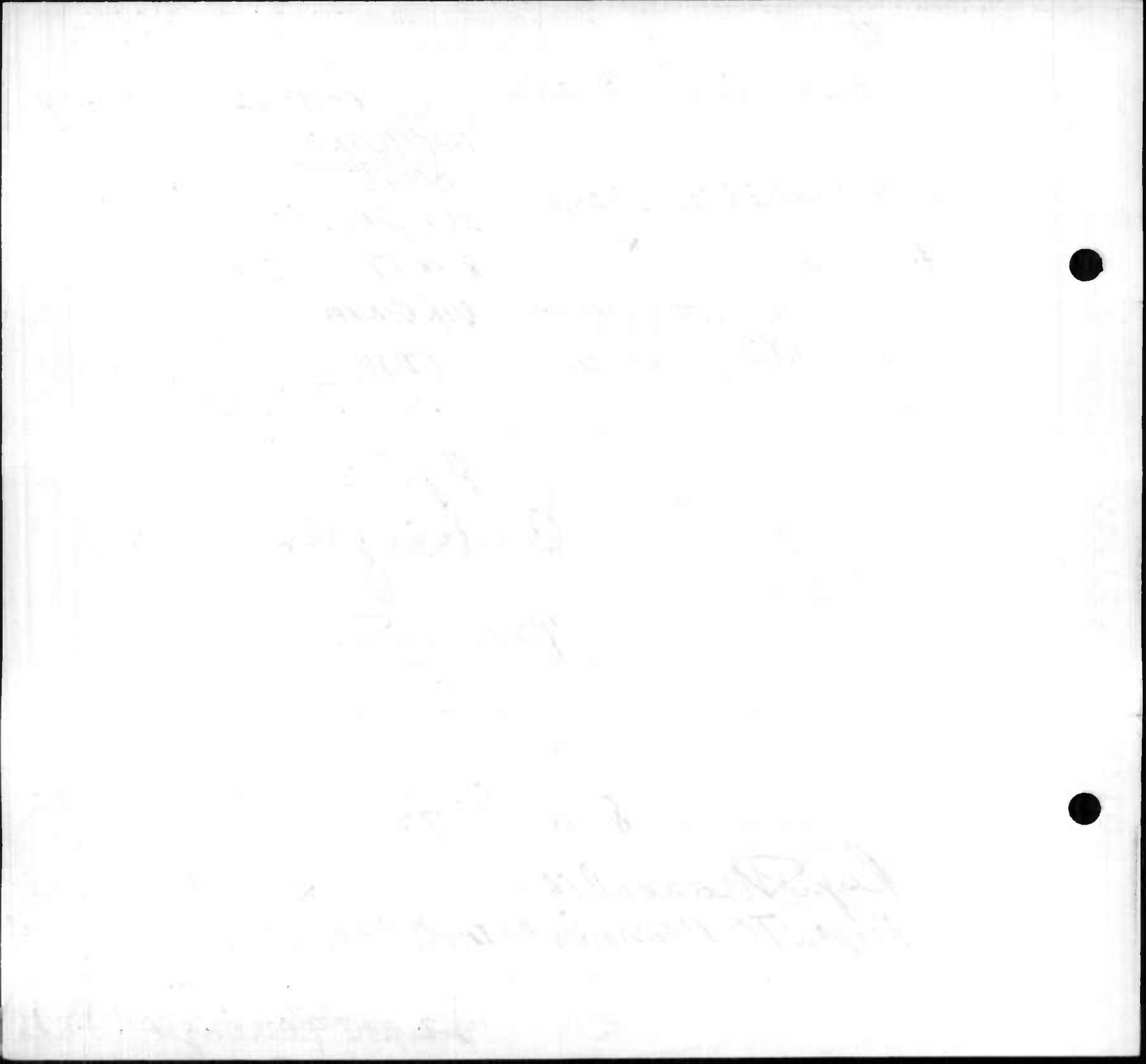
THE JAMES HOPKINS HOSPITAL

JAMES K. BROWN M.D.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

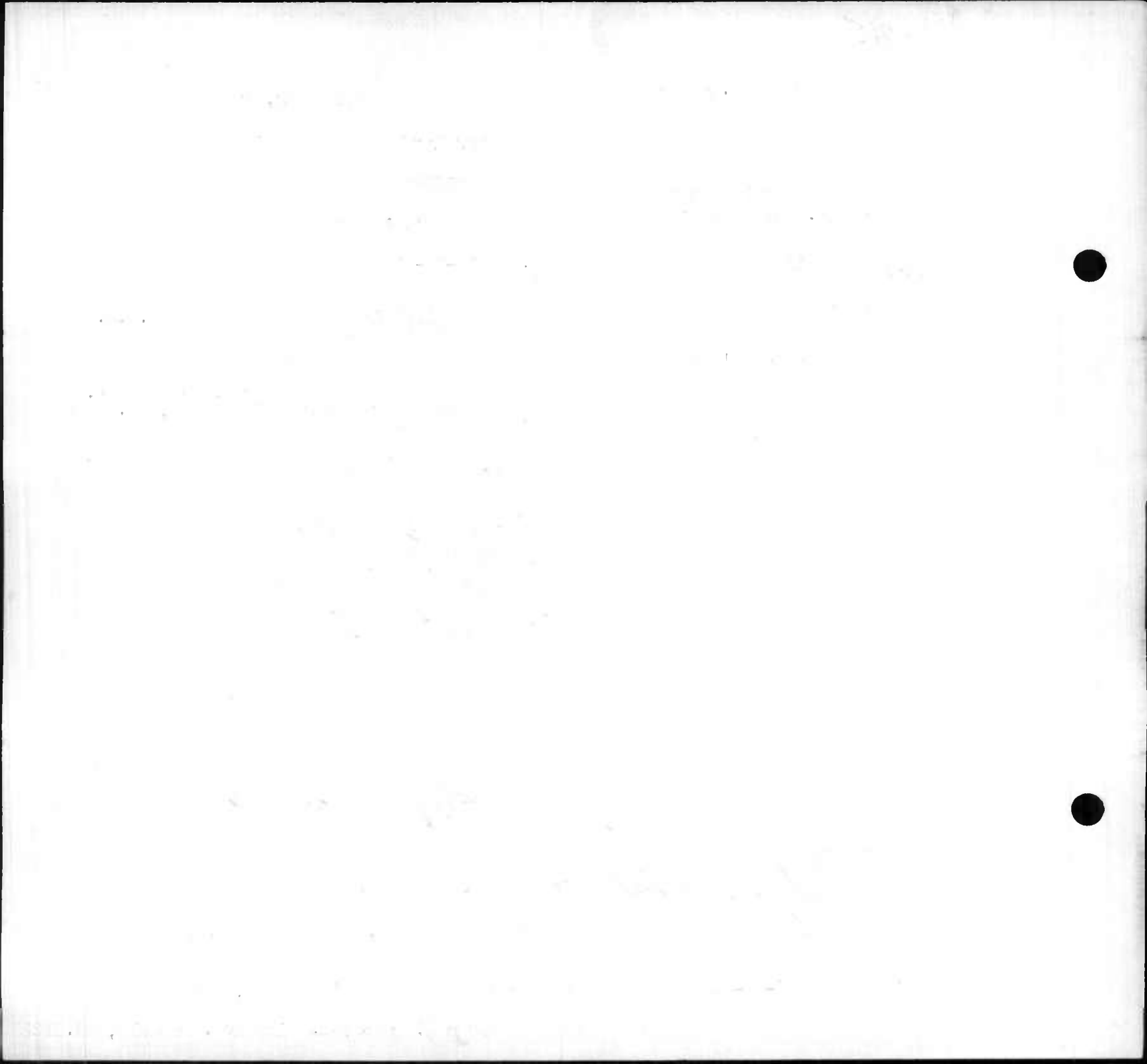
B-252		72 07753		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 07753	
BIRTH NO.		1. NAME OF DECEASED <u>Flora H. Buckingham</u>				2. DATE AND HOUR OF DEATH <u>8-11-72</u> <u>8:50 P.M.</u>			
(Type or Print) <u>BUCKINGHAM FLORA</u>						STATE OF MARYLAND-DHMH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						A. STATE <u>MARYLAND</u>		B. COUNTY <u>1803</u>	
<u>NORTH CHARLES GEN. HOSP</u>						C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>49</u>						E. STREET AND NUMBER <u>51 S. Carrollton Avenue</u>			
						<u>51 S CAROLLTON</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-28-17</u>		9. AGE (in years last birthday) <u>54</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
<u>Psychiatric Attendant</u>		<u>Spring Grove State Hospital</u>		<u>VIRGINIA</u>			<u>United States</u>		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME			
<u>JAMES HADUE HARMON</u>						<u>(D) MARY VIRGINIA KITTIS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			
<u>No</u>						<u>Newberry Funeral Home</u>			
						<u>N. Main St. Bland, Virginia 24315</u>			
18. CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)						(A) IMMEDIATE CAUSE			
						<u>Hepatic Failure</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) <u>Cancer of the Liver</u>			
						<u>YPS</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						<u>Pneumonia</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
<u>0</u>				<u>No</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
<input type="checkbox"/>				<input type="checkbox"/>					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from <u>8-9</u> 19 <u>72</u> to <u>8-11</u> 19 <u>72</u> and that (I) (we) last saw the deceased alive on <u>8-11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE						23B. DATE SIGNED			
<u>Ryder Manankil</u>						<u>8-11-72</u>			
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS			
<u>RYDER TO MANANKIL MD</u>						<u>NORTH CHARLES GEN HOSP MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county)		24E. (State)	
<u>Burial</u>		<u>8-14-72</u>		<u>Rose Hill Cemetery</u>		<u>Bastian, Bland Co., Virginia</u>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS			
<u>AUG 15 1972</u>		<u>Dr. J. H. ...</u>		<u>John P. Duda</u>		<u>7927 Wise Ave Dundalk MD 21222</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

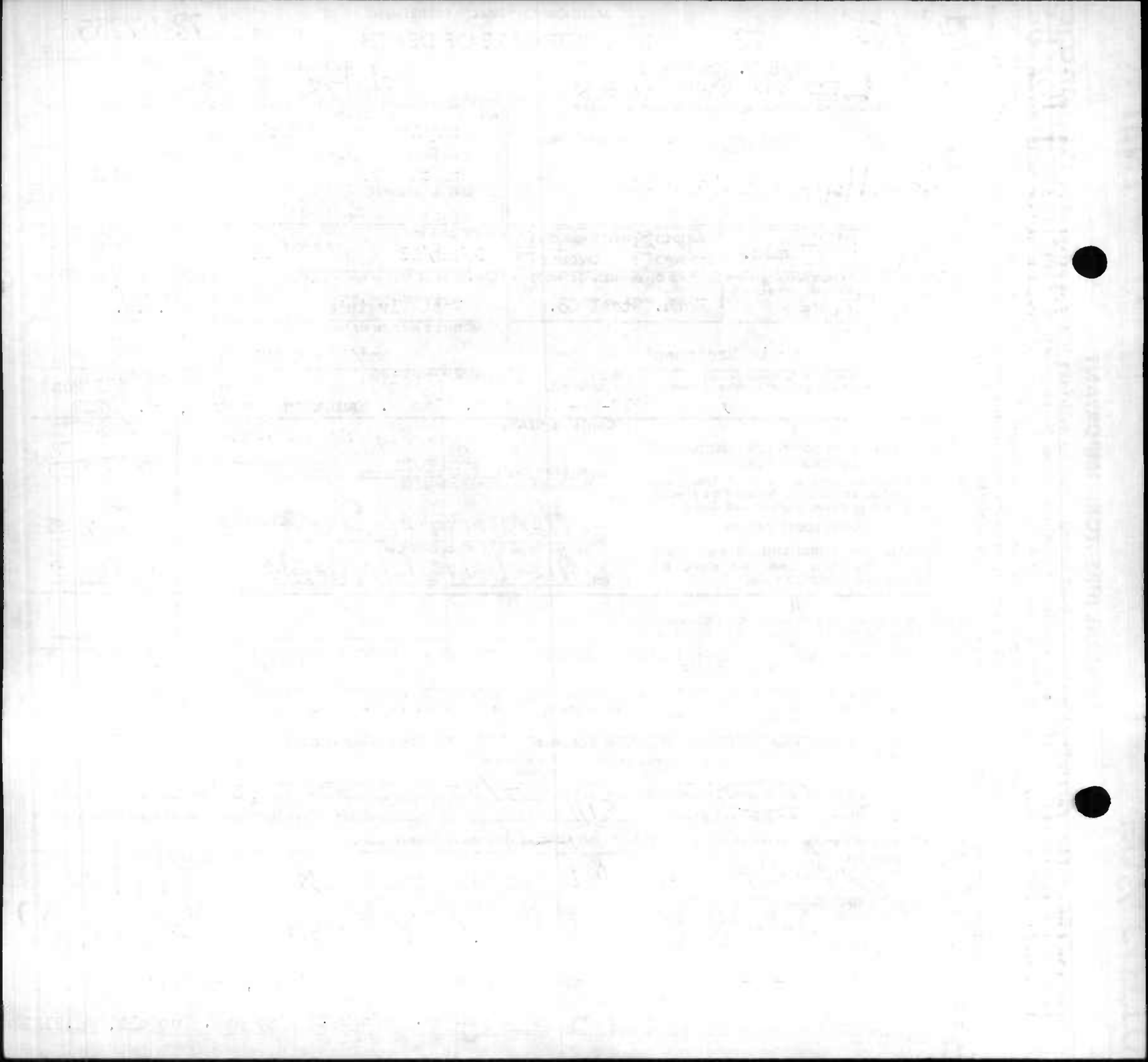
<p>C-265 72 07754 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 07754</p> <p style="font-size: 0.8em;">STATE OF MARYLAND-DHMH</p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) Julia E. Cochran</p>		<p>2. DATE AND HOUR OF DEATH August 12, 1972</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Midtown Nursing Home 808 St. Paul Street</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore</p> <p>C. CITY OR TOWN Sparrows Point D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER 619 F Street</p>	
<p>5. SEX Female</p>	<p>6. RACE White</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 10-11-91</p>
<p>9. AGE (In years last birthday) 80</p>		<p>If Under 1 Yr. Months: Days: Hours: Min.</p>	<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>
<p>11. BIRTHPLACE (State or foreign country) Virginia</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME Daniel O'Leary</p>		<p>14. MOTHER'S MAIDEN NAME Mollie Rose</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. None</p>	<p>17. INFORMANT 302 S. Loudoun St. Winchester, Va. 22601</p>
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Terminal Pneumonia</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Terminal Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: A.S.C.V. Disease (C) Generally of Arteriosclerosis</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days</p>		<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chr. Brain Syndrome</p>	
<p>19A. DATE OF OPERATION 8/11/72</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No</p>	
<p>20A. AUTOPSY? (Yes or No) No</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 8/11/72 to 8/11/72 that (I) (we) last saw the deceased alive on 8/11/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Joseph S. Blum</p>		<p>23B. DATE SIGNED</p>	
<p>23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD</p>		<p>23D. ADDRESS 1115 N. CALVERT ST.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 8-15-72</p>	
<p>24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State) Winchester, Virginia</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972</p>		<p>25B. NAME OF REGISTRAR Lindsey H. Hinton</p>	
<p>25C. FUNERAL DIRECTOR John J. Duda</p>		<p>ADDRESS 7922 Wise Ave. Dundalk, Md. 21222</p>	



FUNERAL DIRECTOR: IMPORTANT

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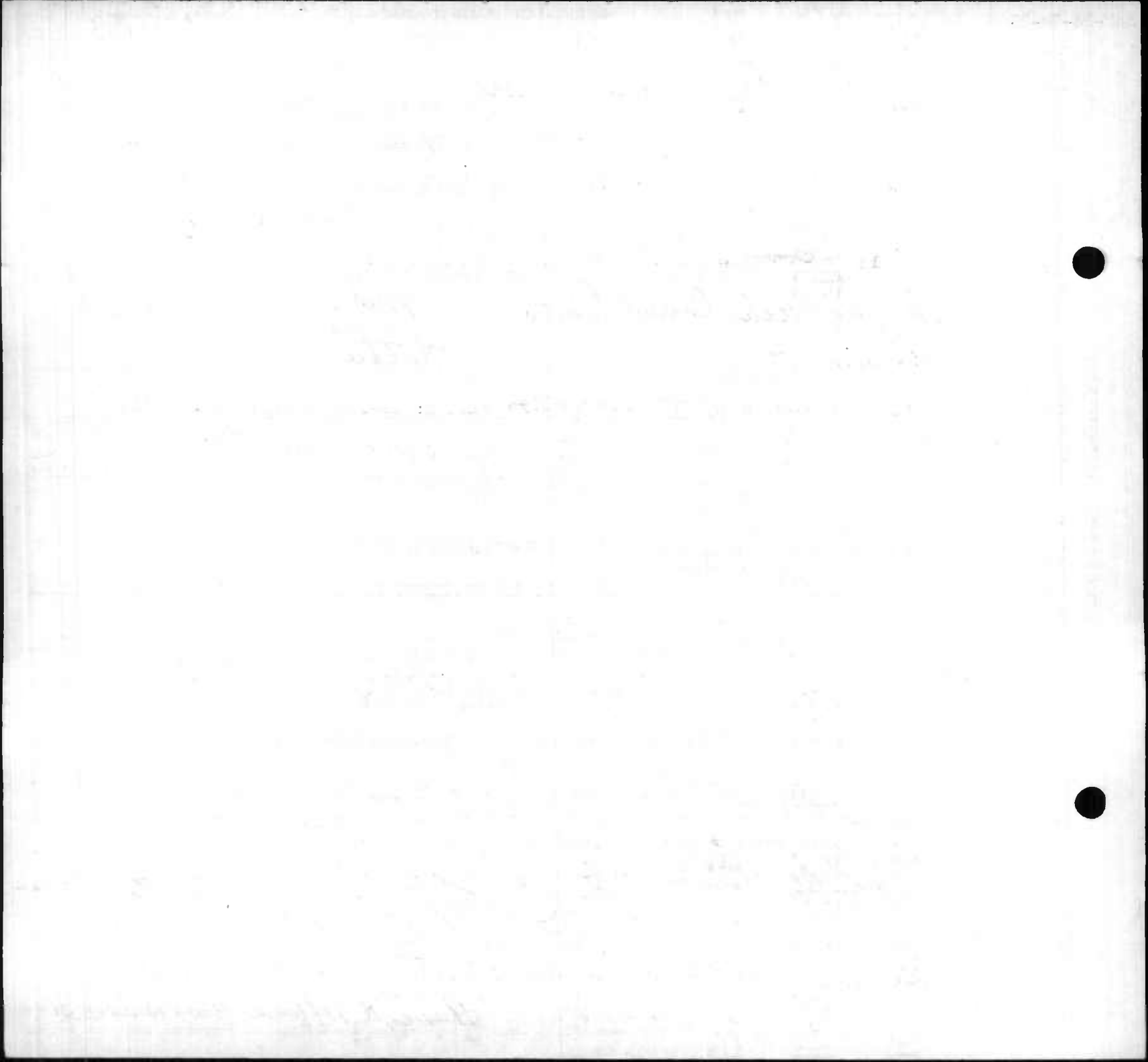
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07755	
R-355 72 07755		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Leo W. Rautanen		2. DATE AND HOUR OF DEATH 8/11/72 9:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital		A. STATE Maryland B. COUNTY Baltimore	
5. SEX M 6. RACE Cauc. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER		E. STREET AND NUMBER 6850 German Hill Road	
10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.		9. AGE (In years last birthday) 59	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Rautanen		14. MOTHER'S MAIDEN NAME Matilda Keskinen	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-2088	
17. INFORMANT Wife: Mrs. Elma H. Rautanen		ADDRESS 6850 German Hill Road Dundalk, Md. 21222	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 571.0 I CARDIAC ARREST Alcoholic Cirrhosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HEPATOMENAL SYNDROME 5 DAYS	
		(B) DUE TO, OR AS A CONSEQUENCE OF: ALCOHOLIC CIRRHOSIS 6 YEARS	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/28 19 72 to 8/11 19 72 that (I) (we) last saw the deceased alive on 8/11 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE John W. Kraus M.D.		23B. DATE SIGNED 8/11/72	
23C. PHYSICIAN'S NAME (Type) John W. Kraus M.D.		23D. ADDRESS 601 N. Broadway Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 8-14-72	
24C. NAME of CEMETERY or CREMATORY Loudon Park Crematory		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972		25B. NAME OF REGISTRAR Sidney H. Weston	
25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md. 21222	



FUNERAL DIRECTOR: IMPORTANT

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S-462		72 07756		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07756	
BIRTH NO.		72 07756		CERTIFICATE OF DEATH		STATE OF MARYLAND - DEPT. OF HEALTH	
1. NAME OF DECEASED (Type or Print) <i>George S. Silberstein Jr.</i>				2. DATE AND HOUR OF DEATH <i>8/13/72 1:20 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2611</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospital</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>3226 Elliott St Balt 21204</i>							
5. SEX <i>Male</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/1/20</i>	9. AGE (In years last birthday) <i>51</i>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shipping Clerk</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Cannal Limited</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
13. FATHER'S NAME <i>Louis H.</i>				14. MOTHER'S MAIDEN NAME <i>Hettie</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>Yes Army WW II</i>				16. SOCIAL SECURITY NO. <i>220-01-3944</i>		17. INFORMANT ADDRESS <i>Records: BCH-4940 Eastern Ave. 21224</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>acute myocardial infarction</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 minutes</i>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>None</i>							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>None</i>							
21A. DATE OF OPERATION <i>2</i>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		21C. AUTOPSY (Yes or No) <i>yes</i>		21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>—</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Inotify medical examiner <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <i>—</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>—</i>			
21D. TIME OF INJURY (APPROX.) <i>—</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>—</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>8/13/72</i> 19 <i>—</i> to <i>8/13/72</i> 19 <i>—</i> that (I) (we) last saw the deceased alive on <i>8/13/72</i> 19 <i>—</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>John W. Kirk, M.D.</i>				23B. DATE SIGNED <i>8/13/72</i>			
23C. PHYSICIAN'S NAME (Type) <i>JOHN W. KIRK, M.D.</i>				23D. ADDRESS <i>Balt City Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-16-1972</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 15 1972</i>		25B. NAME OF REGISTRAR <i>—</i>		25C. FUNERAL DIRECTOR <i>Thelma R. Hoffman</i>		ADDRESS <i>3218 Hudson St.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07757	
CERTIFICATE OF DEATH				X REG. NO. 72 07757	
<div style="display: flex; justify-content: space-between;"> D-200 72 07757 </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) Ernest Diggs			2. DATE AND HOUR OF DEATH Aug 6 1972 10 40 p. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION University of Maryland Hospital 38			A. STATE Spring Grove State Hospital B. COUNTY 5300		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER					
5. SEX M	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/31/02	9. AGE (in years last birthday) 69	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Uxon, Hill	
13. FATHER'S NAME James H. Diggs		14. MOTHER'S MAIDEN NAME Anna Diggs		12. CITIZEN OF WHAT COUNTRY? Prince Geo. Co.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-34-4450-A		17. INFORMANT Charlotte E. Barnett 2705- Robinson, Pl. S.E.	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Chronic Renal Failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		2 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mark H. Krowitz		23B. DATE SIGNED 8/6/72		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) MARK H. KROWITZ MD		23D. ADDRESS 2500 - M. L. King Ave. S.E.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/12/72		24C. NAME of CEMETERY or CREMATORY Lincoln Memorial	
24D. LOCATION (City, town, or county) (State) Suitland, Maryland					
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972		25B. NAME OF REGISTRAR Robert G. Mason		25C. FUNERAL DIRECTOR ADDRESS 2500 - M. L. King Ave. S.E.	

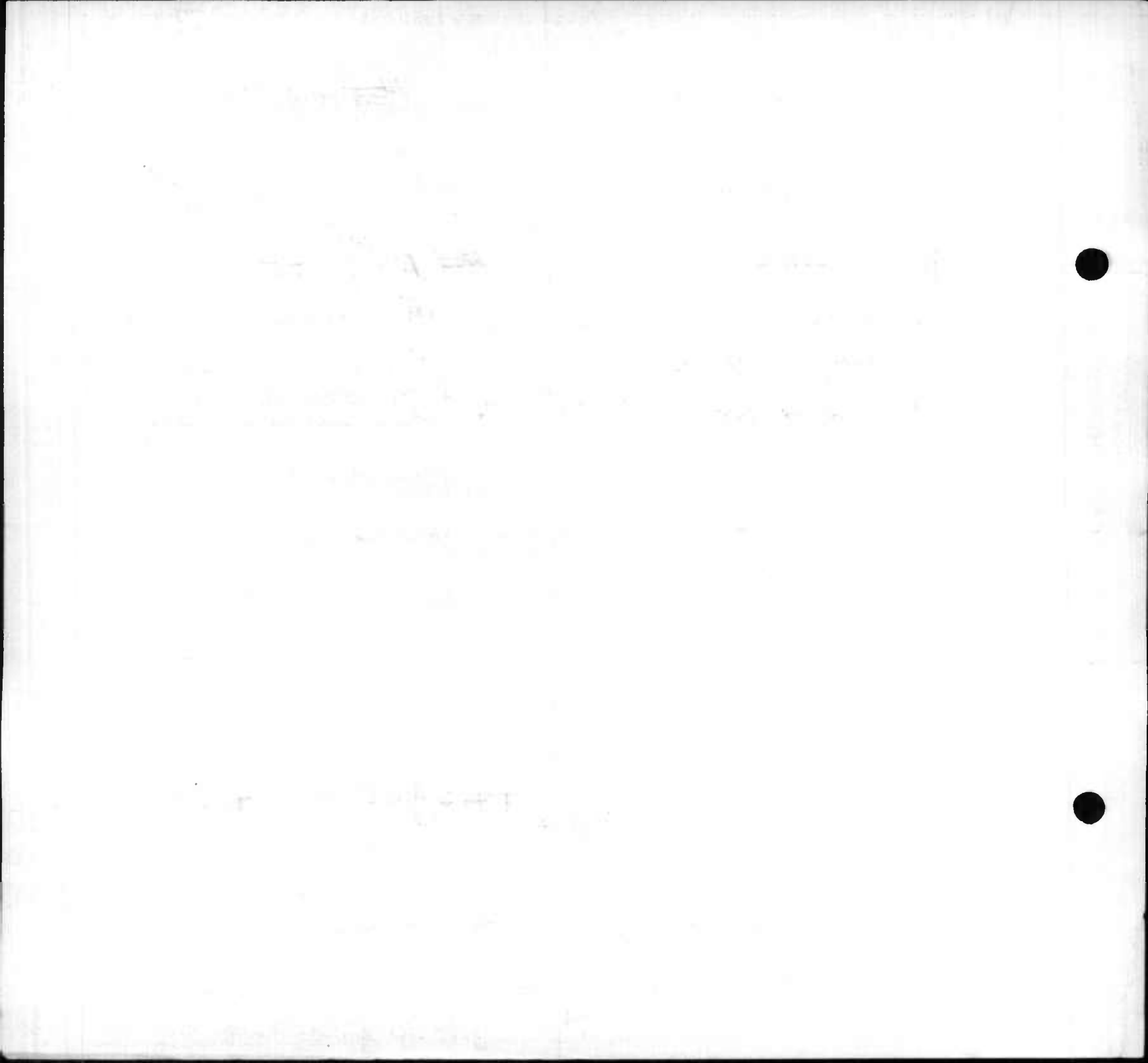
1/27/66 - Adm.

[Faint, illegible handwritten signature or text]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 07758		72 07758	
BIRTH NO. <u>W-456</u>		72 07758		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Wilmer, Anne</u>		2. DATE AND HOUR OF DEATH <u>Aug. 5th 1972 4:00 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>The Union Memorial Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1203</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Union Memorial Hosp.</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>Calvert Street 2708 N.</u>					
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Jan 23 1917</u>		9. AGE (In years last birthday) <u>55</u>		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>HARRY WHITE</u>		14. MOTHER'S MAIDEN NAME <u>CARRIE TULL</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-22-5540</u>		17. INFORMANT <u>Jerome Wilmer</u> ADDRESS <u>2708 N. Calvert St. Baltimore 21218</u>	
18. <u>431.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Central failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cerebral thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If only medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 4 1972</u> to <u>Aug 5 1972</u> that (I) (we) last saw the deceased alive on <u>Aug 4 1972</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Chung Hsien Yu</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>CHUNG-HSIEN YU</u>	
23D. ADDRESS <u>The Union Memorial Hosp., Baltimore Maryland 21218</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8-14-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL Cem.</u>	
24D. LOCATION <u>TOWSON, BALTO. MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Weston</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Inc. Towson, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 07759</u>	
BIRTH NO. <u>H-400</u>		72 07759		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MARTHA Hill</u>			2. DATE AND HOUR OF DEATH <u>August 3, 1972 9:40 AM.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND GENERAL HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE CITY</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>607 PENNSYLVANIA AVE. 1701</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/8/86</u>	9. AGE (In years last birthday) <u>86</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>P. PRESTON</u>			14. MOTHER'S MAIDEN NAME <u>P. Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>181 22 9134</u>		17. INFORMANT <u>CHART</u> ADDRESS
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>BRONCHIOGENIC CARCINOMA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		
19. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>July 18, 1972</u> to <u>August 3, 1972</u> that (I) (we) last saw the deceased alive on <u>August 3, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Newton W. Rogers MD</u>			23B. DATE SIGNED <u>8/3/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Newton W. Rogers M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>8-7-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Frostburg Memorial Park</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1972</u>			25B. NAME OF REGISTRAR <u>Sidney H. Houghton</u>		25C. FUNERAL DIRECTOR <u>Harry W. Haight Lykensville, Md.</u>

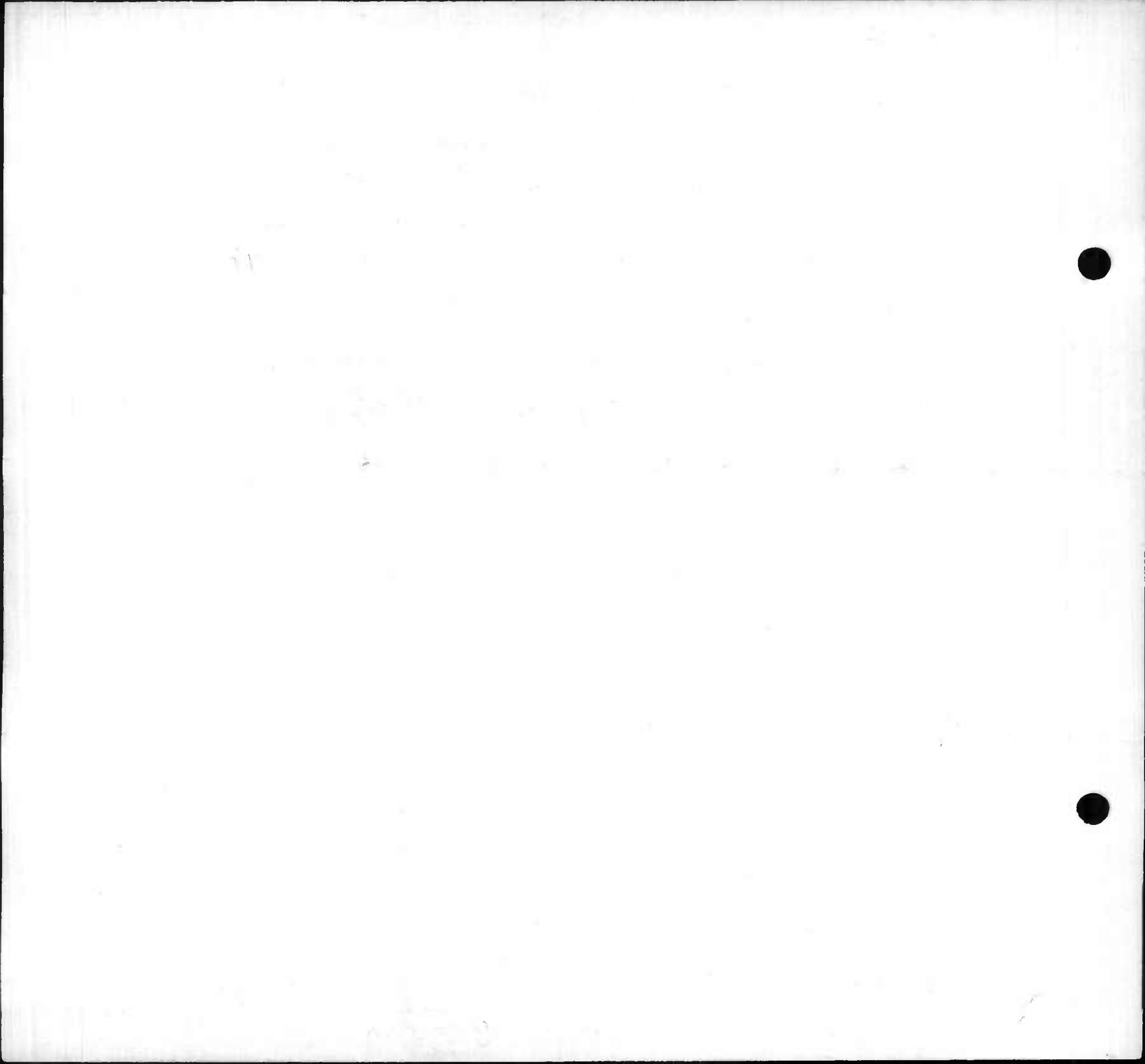
7/7/64 - Adm.

7/7/64 - Adm.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

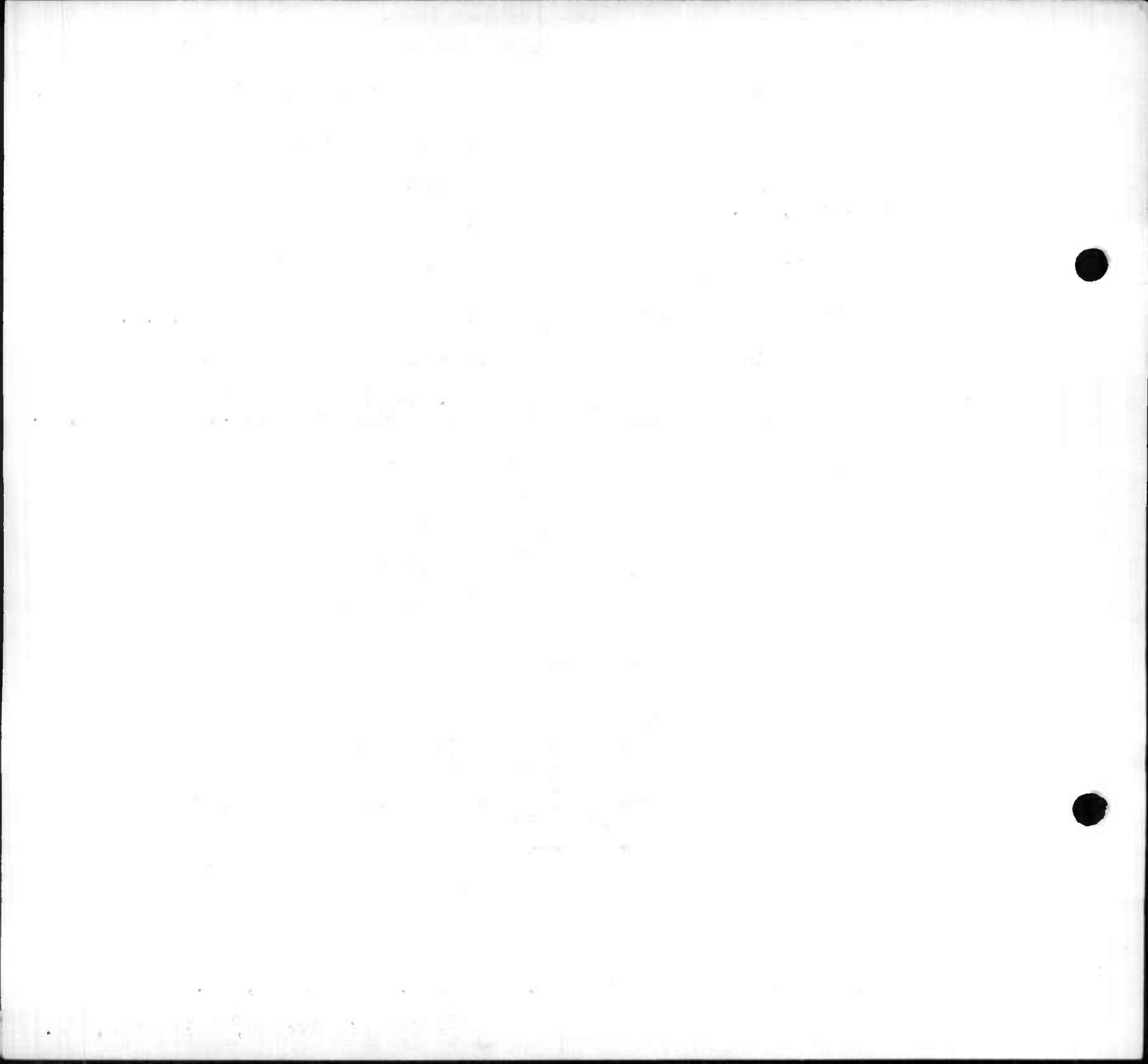
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 07760	
BIRTH NO. <u>H-616</u>		72 07760		STATE OF MARYLAND-DHME	
1. NAME OF DECEASED (Type or Print) <u>HERBERT, JOHN W.</u>			2. DATE AND HOUR OF DEATH <u>8/8/72</u> <u>1-45 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>LUTHERAN HOSPITAL OF MD</u> <u>46</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2833</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2108 MOSBY AVE</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1894</u>	9. AGE (in years last birthday) <u>77</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FISHERMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VA.</u>	
13. FATHER'S NAME <u>JOSEPH W HERBERT.</u>			14. MOTHER'S MAIDEN NAME <u>CUNNINGHAM</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-14-9186</u>		17. INFORMANT <u>HOWARD HERBERT</u> <u>RT2. Montross W. MORELAND Co. VA.</u>	
18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CARDIOGENIC SHOCK</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>A-S-H-D - ANEMIA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/7/72</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>8/3/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. SANDOZ M.D.</u>			23B. DATE SIGNED <u>8/8/72</u>		23C. PHYSICIAN'S NAME (Type) <u>E. SANDOZ M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8-11-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>WESTERN</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore City</u> <u>MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1972</u>			
25B. NAME OF REGISTRAR <u>Frank H. Saitz</u>		25C. FUNERAL DIRECTOR <u>814 W 36th ST.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-326 72 07761		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 07761	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GUS COTSORADIS		August 9, 1972 11:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
3617 Loch Raven Boulevard Baltimore, Md.				Maryland Baltimore 903	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				3617 Loch Raven Boulevard	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-10-97	75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Restaurant Owner		Food		Greece	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Steve Cotsoradis			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			215-32-8133		
17. INFORMANT			ADDRESS		
Mrs. Angela Cotsoradis			3617 Loch Raven Blvd., Baltimore, Md.		
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				1 hr.	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8/10/1972 to 8/9/72 that (I) (we) last saw the deceased alive on 8/9/72 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				8/10/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
MARION FRIEDMAN MD				5211 Harford Rd	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8-14-72		Moreland Mem. Park Cem.	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 15 1972				Nicholas H. Matthews	
				ADDRESS	
				3021 Eastern Avenue, Baltimore, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-563		72 07762		BALTIMORE CITY HEALTH DEPARTMENT		72 07762	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
HAROLD LEONHARDT		Aug 11, 1972 9 P.M.		Ash Burton Nursing Home		md Baltimore 1102	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Ash Burton Nursing Home		90		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
male		white				6-25-06 66 yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
?		Lena ?		Unknown		218-26-2875-M	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		17. INFORMANT		ADDRESS	
478.9 I		auto coronary					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE		DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(B) Hypertensive C.V. disease		DUE TO, OR AS A CONSEQUENCE OF:		years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) arterial thrombosis		DUE TO, OR AS A CONSEQUENCE OF:		years	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from		7/9 19 71 to		8/11 19 72			
that (I) (we) last saw the deceased alive on		8/11 19 72		and that in (my) (our) opinion death occurred on the date			
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
[Signature]		8/11/72		Kenneth A. Mace		26 Reed St Mt. Calvary	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-14-72		Mt. Calvary		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 15 1972		Sidney [Signature]		Kenneth Law		4611 Park Heights Ave.	

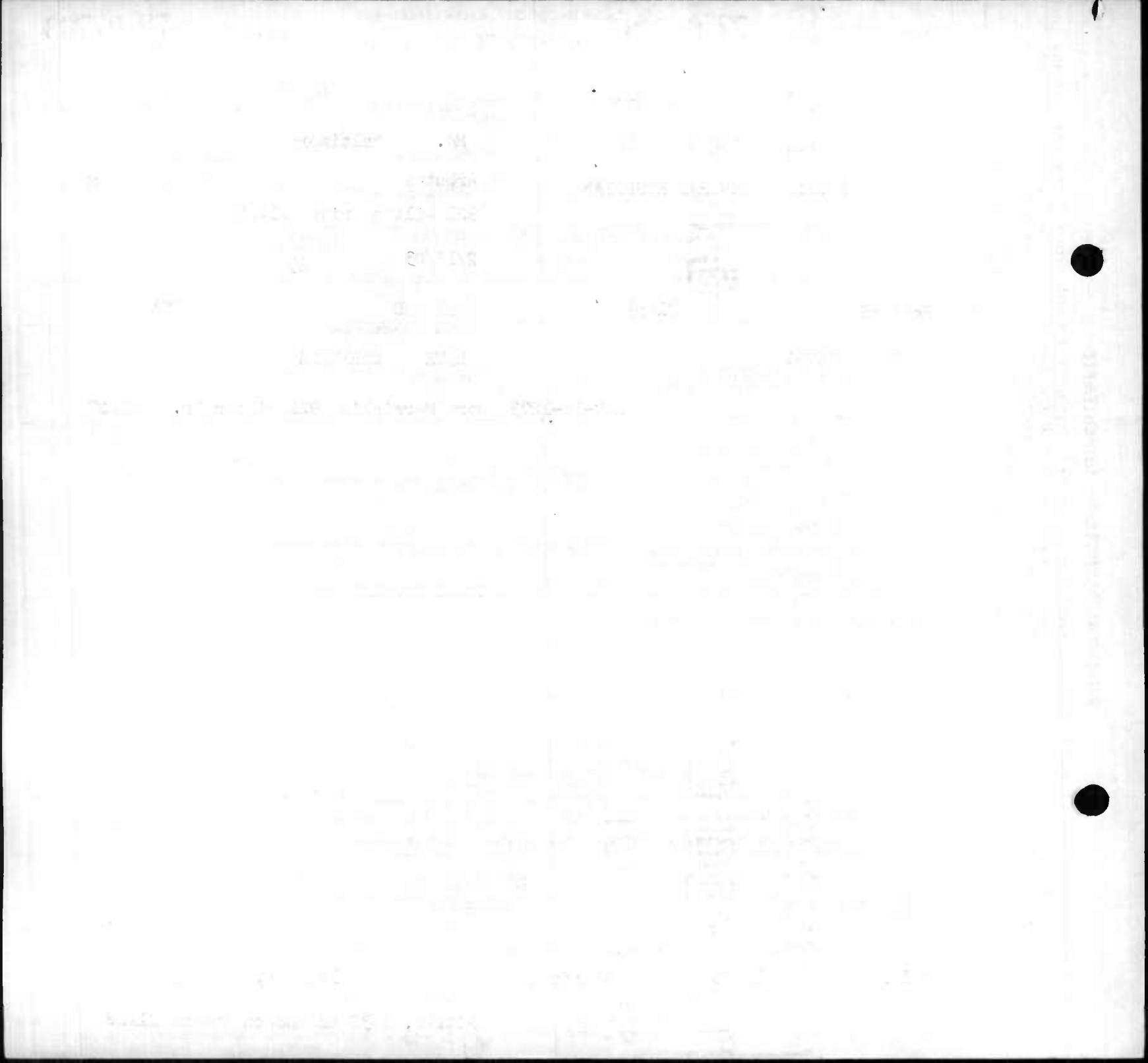
7/9/71

The ALCANTARA, cathedral & Madison

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07763		72 07763	
M-622				72 07763		72 07763	
BIRTH NO.				72 07763		72 07763	
1. NAME OF DECEASED (Type or Print) <u>Rose Marsiglia</u>				2. DATE AND HOUR OF DEATH <u>8/12/72</u> <u>1 30</u> <u>P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 MARYLAND GENERAL HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Arbutus</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>921 Wilton Drive 21227</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/03</u>		9. AGE (In years last birthday) <u>69</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Clerk</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LATE ANTHONY</u>				14. MOTHER'S MAIDEN NAME <u>LATE CARMELLA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-38-1273</u>		17. INFORMANT ADDRESS <u>Dora Marsiglia 921 Wilton Dr. 21227</u>			
18. <u>174X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Central Nervous System Metastasis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Carcinoma of Breast</u> 19A. DATE OF OPERATION <u>1971</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u> <u>1963</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> <u>19 71</u> to <u>8/12</u> <u>19 72</u> that (I) (we) last saw the deceased alive on <u>8/12</u> <u>19 72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Arthur A. Sorpick</u> DEGREE <u>MD</u>				23B. DATE SIGNED <u>8/11/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Arthur A. Sorpick MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/16/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1972</u>				25B. NAME OF REGISTRAR <u>Sidney Witzke</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Witzke, 1630 Edmondson Avenue 21228</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-634		72 07764		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07764	
BIRTH NO.				CITY HEALTH DEPARTMENT			
1. NAME OF DECEASED (Type or Print) WARDLE HARRY				2. DATE AND HOUR OF DEATH 8/13/72 10.50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 107 UPMANOR ROAD			
5. SEX M	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-90	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN				10B. KIND OF BUSINESS OR INDUSTRY Retired - bookkeeper		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME ANDREW WARDLE			
14. MOTHER'S MAIDEN NAME ANNIE C FAIRBANKS				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN			
16. SOCIAL SECURITY NO. 213-03-2789 A				17. INFORMANT ADDRESS Mrs. Emma Wardle 107 Upmanor Rd. 21229			
18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Atherosclerotic cardiovascular disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? —		22. I certify that (I) (this hospital) attended the deceased from 7-28-1972 to 8-13-1972 , that (I) (we) lost saw the deceased alive on 10:50 AM 8/13/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Peter H. Joyce M.D.				23B. DATE SIGNED 8/15/72		23C. PHYSICIAN'S NAME (Type) PETER H. JOYCE, M.D.	
23D. ADDRESS —		23E. ADDRESS —		23F. ADDRESS —		23G. ADDRESS —	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/72		24C. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972		25B. NAME OF REGISTRAR Sidney W. Wilson		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue		25D. ADDRESS 21228	

PETER H. JOSE, N.Y.

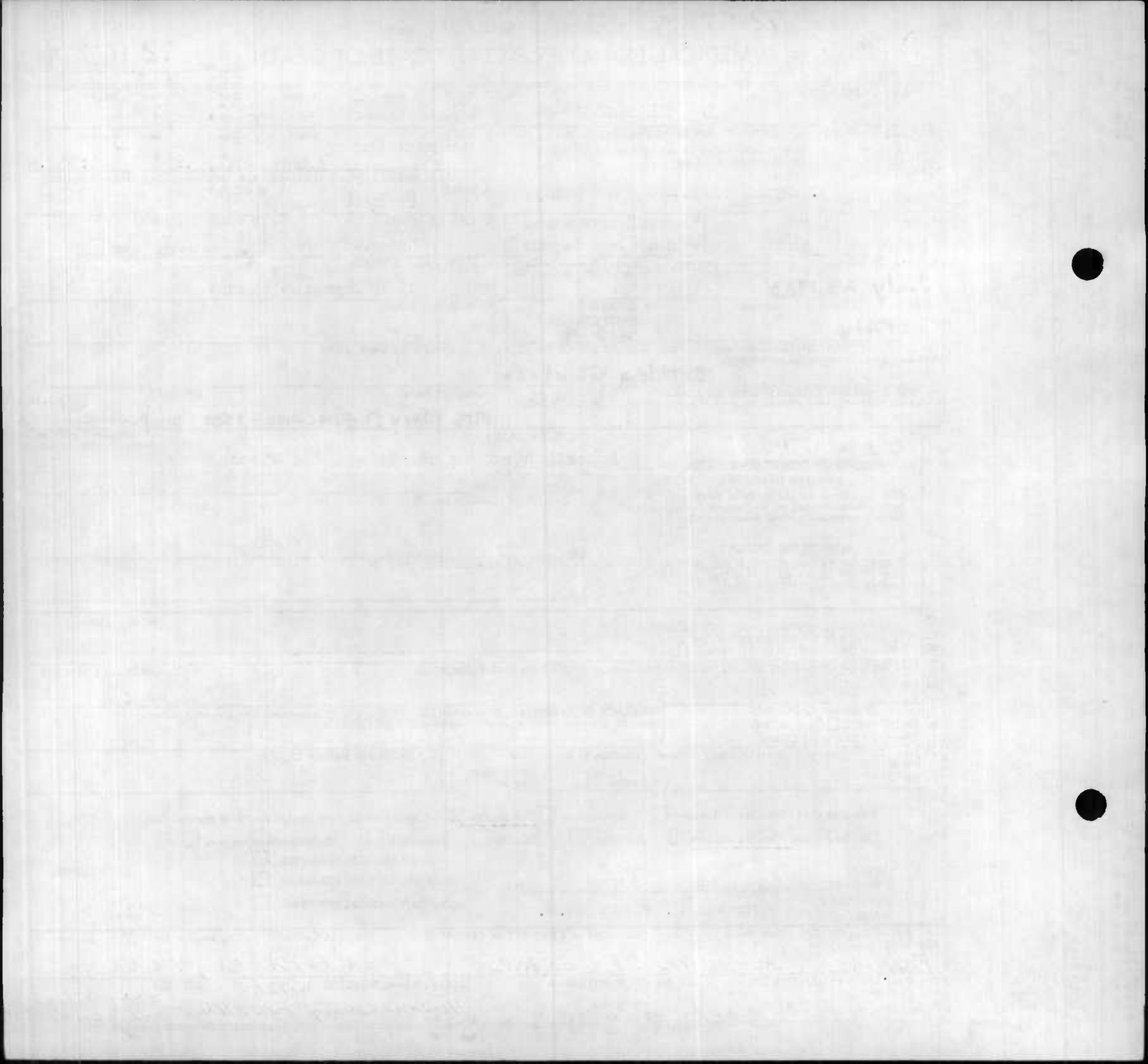
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07765

BIRTH NO.

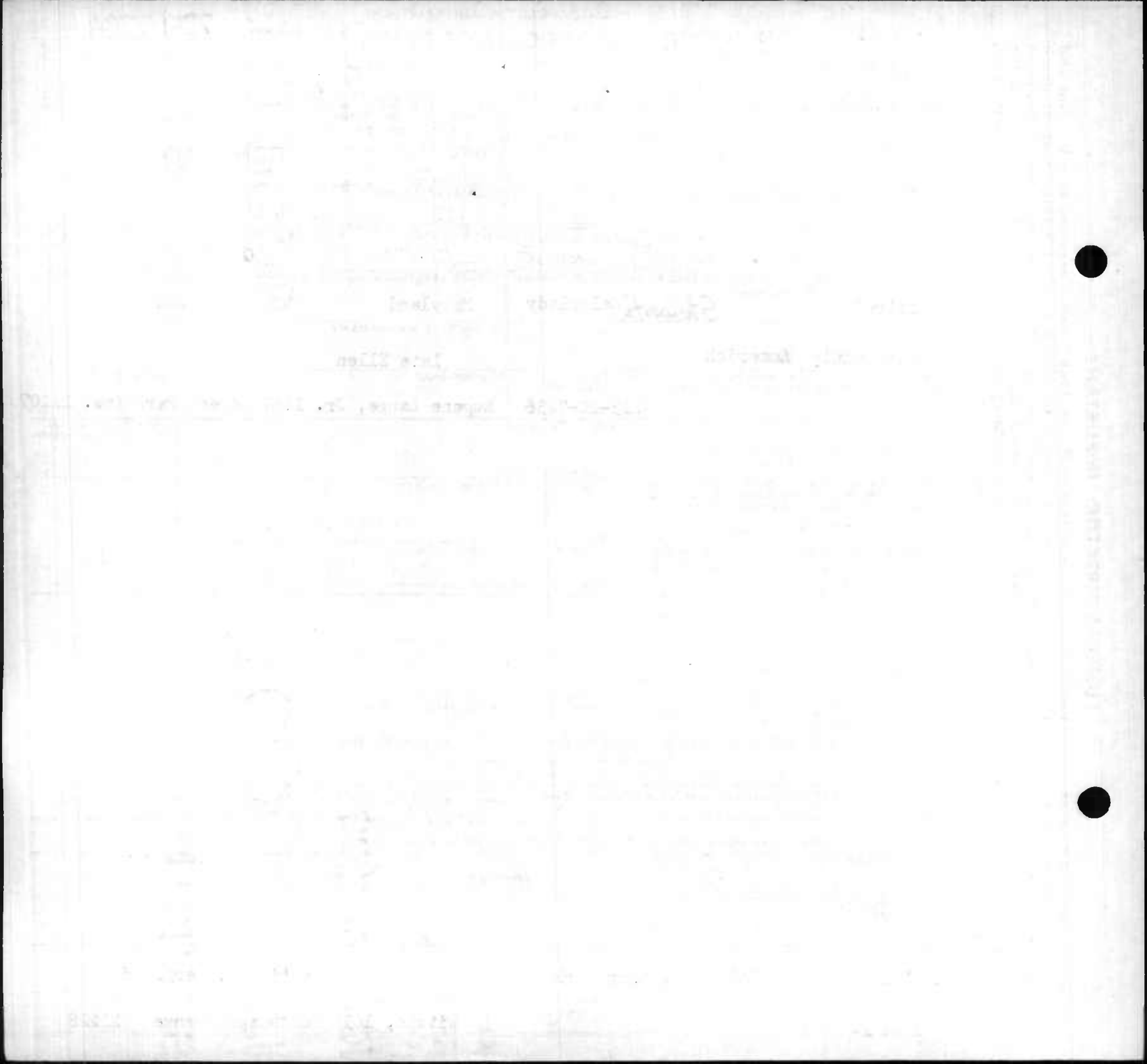
1. NAME OF DECEASED (Type or Print) SAMUEL DIGIACOMO		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year August 12, 1972 Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour August 12, 1972 11:35A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Lebanon	
9. DATE OF BIRTH July 23, 1903		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) 65		E. STREET AND NUMBER 1550 Thompson Avenue	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bethlem Steel - PA.		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs. Mary DiGiaco - 1550 Thompson Ave. PA		ADDRESS Lebanon	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Marvin S. Platt, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 13, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Aug. 16, 1972	
24C. NAME OF CEMETERY or CREMATORY ST. GERTRUDE		24D. LOCATION (City, town, or county) (State) N. LEBANON, PENNA	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972		25B. NAME OF REGISTRAR A. J. [Signature]	
25C. FUNERAL DIRECTOR WITZKE		ADDRESS HOWARD COUNTY FUN, HOWE MARYLAND	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

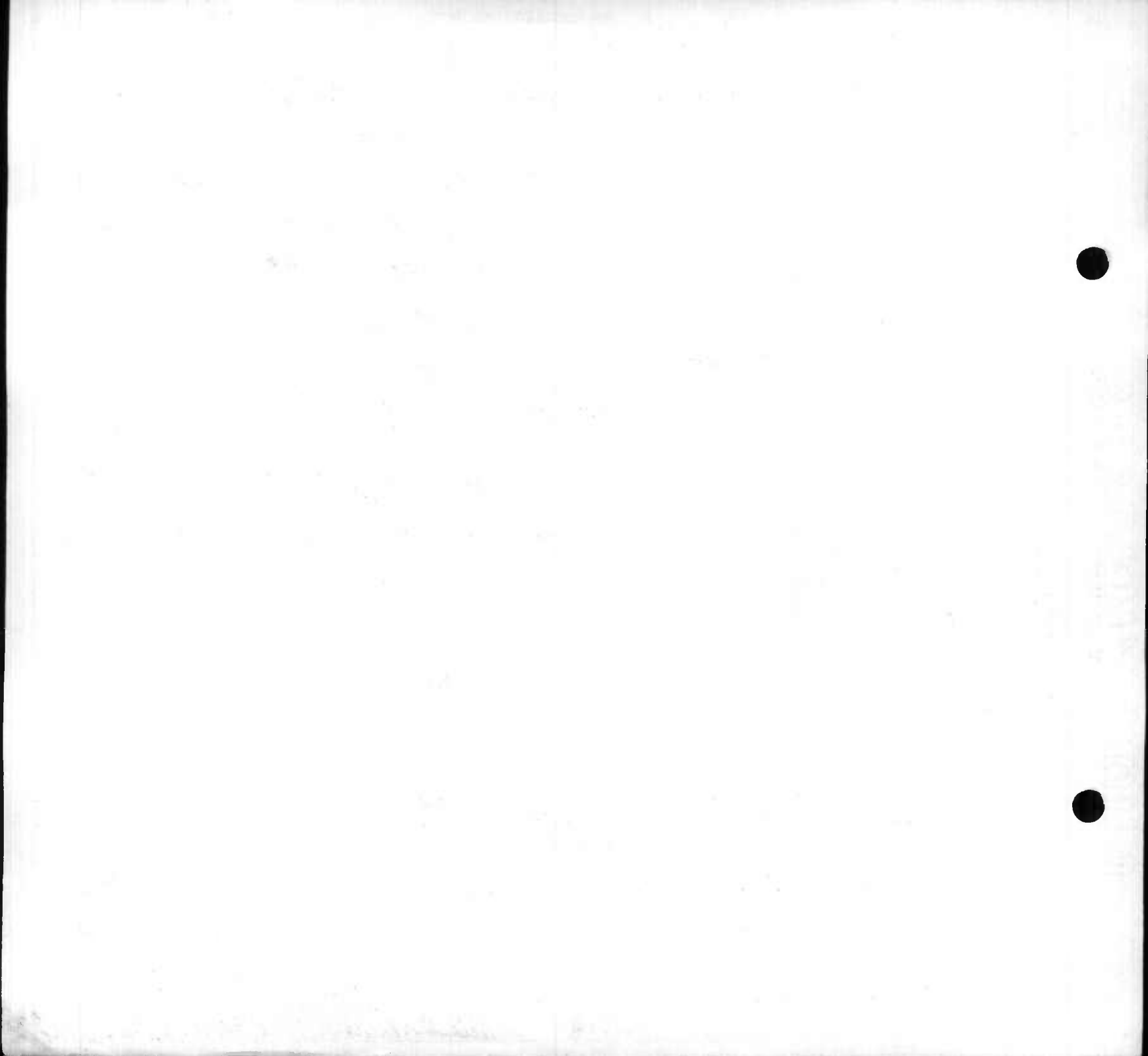
L-100 72 07766				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 07766 STATE OF MARYLAND=DHME	
1. NAME OF DECEASED (Type or Print) <u>LAPPE, ETTA B.</u>				2. DATE AND HOUR OF DEATH <u>8/14/72</u> <u>6 15/AM.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2834</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>723 Brinkwood Road</u>			
5. SEX <u>Female</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/16/01</u>	9. AGE (In years last birthday) <u>70</u>	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Stewart's Saleslady</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>late Ludwig Emmerich</u>				14. MOTHER'S MAIDEN NAME <u>late Ellen</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>213-20-7236</u>		17. INFORMANT <u>Eugene Lappe, Jr.</u> ADDRESS <u>1457 Forest Park Ave. 21207</u>		
18. <u>IX</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>POST OPERATIVE MENINGITIS</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>GLIOBLASTOMA (R)</u> (C) DUE TO, OR AS A CONSEQUENCE OF: <u>FRONTAL LOBE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u> <u>several weeks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Pulmonary embolus 8/5/72</u>							
19A. DATE OF OPERATION <u>7/26/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>glioblastoma (R) frontal lobe</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>N.A.</u>		21C. WHERE DID INJURY OCCUR? <u>N.A.</u>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>N.A.</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <u>N.A.</u>		21F. HOW DID INJURY OCCUR? <u>N.A.</u>			
22. I certify that (1) (this hospital) attended the deceased from <u>7/25</u> 19 <u>72</u> to <u>8/14</u> 19 <u>72</u> and that (2) (we) lost saw the deceased alive on <u>8/13</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Frederick H. Sklar M.D.</u>				23B. DATE SIGNED <u>8/14/72</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>FREDERICK H. SKLAR M.D.</u>				23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL BALTIMORE, MD. 21205</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/17/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Johnston</u>		25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Avenue</u>		ADDRESS <u>21228</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

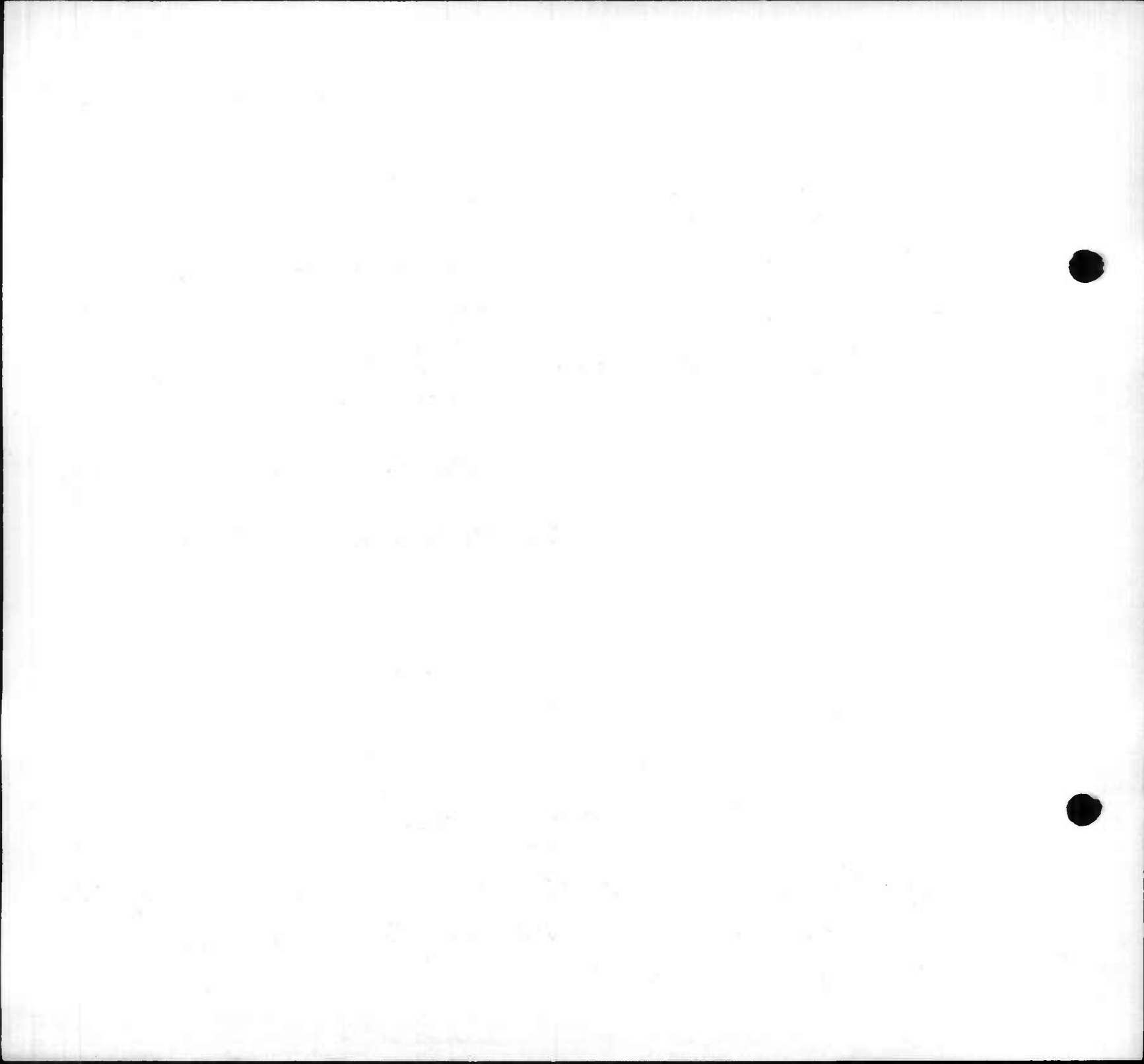
BALTIMORE CITY HEALTH DEPARTMENT 72 07767 CERTIFICATE OF DEATH				REG. NO. STATE OF MARYLAND-DENR	
1. NAME OF DECEASED (Type or Print) GRAHAM, ANNIE BELL		2. DATE AND HOUR OF DEATH 8/8/72 7:45 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MD NOSP 38		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE BALTO MD B. COUNTY 1801 C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 907 W. SARATOGA ST Apt. 4			
5. SEX F	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-17-24	9. AGE (In years last birthday) 48	10. Under 1 Yr. Months: Days: Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.	
13. FATHER'S NAME JULIUS MCCALLUM		14. MOTHER'S MAIDEN NAME MARIE MCCLOUR			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-140582		17. INFORMANT CHAD ADDRESS	
18. 410.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last ACUTE MYOCARDIAL INFARCTION WITH CARDIOGENIC SHOCK AND CARDIAL ARRYTHMIAS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASCVD					
19A. DATE OF OPERATION 0 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/8/72 19 72 to 8/11/72 19 72 that (I) (we) last saw the deceased alive on 8/8/72 19 72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L.A. Fleming MD		23B. DATE SIGNED 8/8/72		23C. PHYSICIAN'S NAME (Type) L.A. FLEMING MD	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/72		24C. NAME OF CEMETERY or CREMATORY W.F. Calvary Cem.	
24D. LOCATION (City, town, or county) (State) Cedar Hill Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972		25B. NAME OF REGISTRAR Lidny	
25C. FUNERAL DIRECTOR William Funeral Home		25D. ADDRESS 319 N. Schroeder St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07768		REG. NO. 72 07768	
CERTIFICATE OF DEATH							
STATE OF MARYLAND-DEMD							
BIRTH NO.		72 07768		1. NAME OF DECEASED (Type or Print) EMMA RUTH JENNINGS		2. DATE AND HOUR OF DEATH 8/4/72 1:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 1301			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 600 WHITELOCK ST. 21217							
5. SEX F	6. RACE BLACK	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/12/24	9. AGE (in years last birthday) 48	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) SO. CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Eddie W. Singleton				14. MOTHER'S MAIDEN NAME Theo Blanding			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS HATTIE EVANS. SAME	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I CARCINOMATOSIS SQUAMOUS CANCER, LUNG				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 MOS.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 8/3 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Artemio M. Cuervo, M.D.				23B. DATE SIGNED 8/4/72		23C. PHYSICIAN'S NAME (Type) Artemio M. Cuervo, M.D.	
23D. ADDRESS Maryland Gen. Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-9-72		24C. NAME OF CEMETERY or CREMATORY MT. CALVARY Cem.		24D. LOCATION (City, town, or County) (State) G.A. County Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972		25B. NAME OF REGISTRAR Tracy H. Hinton		25C. FUNERAL DIRECTOR W. E. Flickson		25D. ADDRESS 1129 N. Caroline St.	

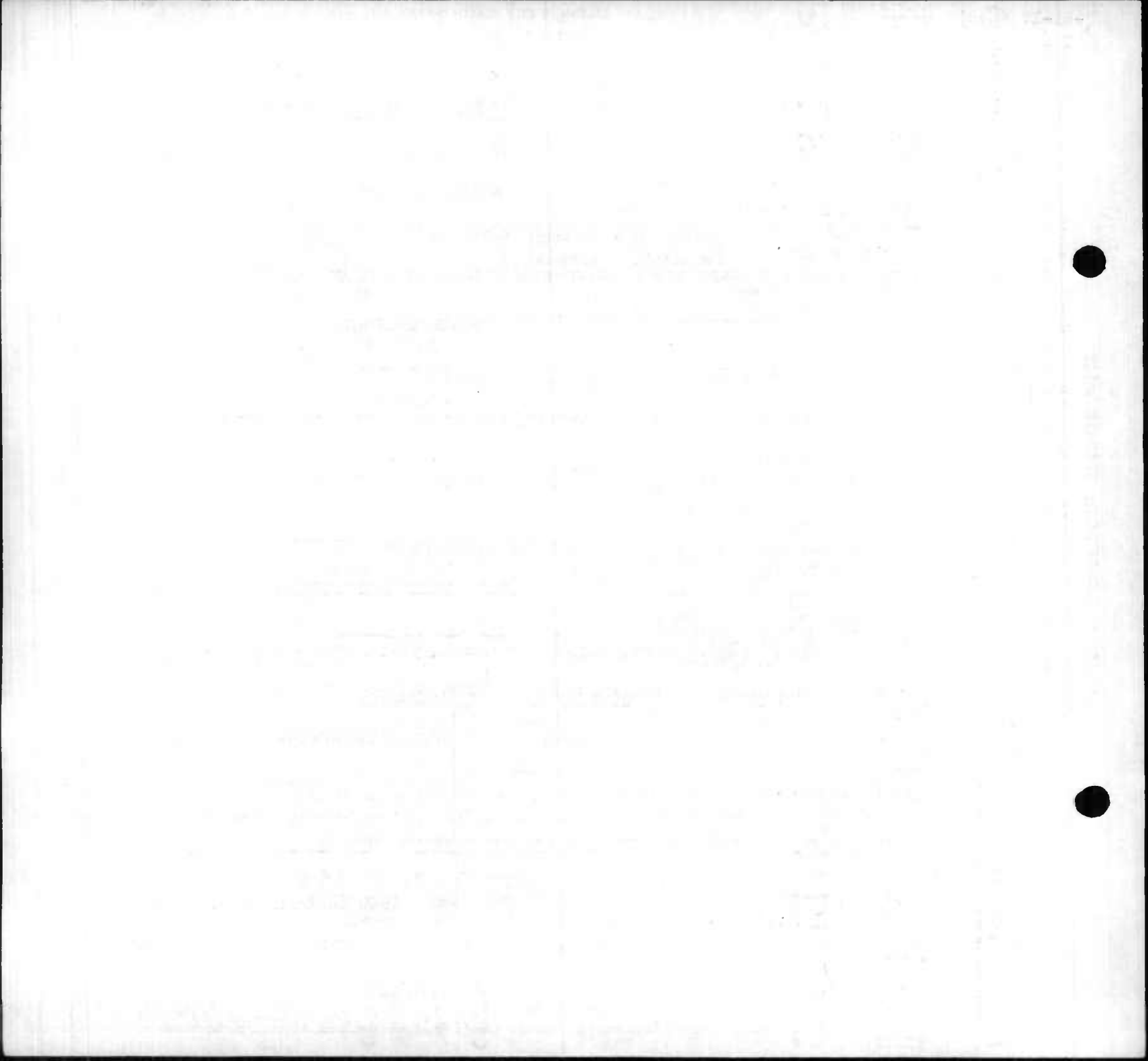


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHREG. NO. 72 07769
STATE OF MARYLAND-DEMH

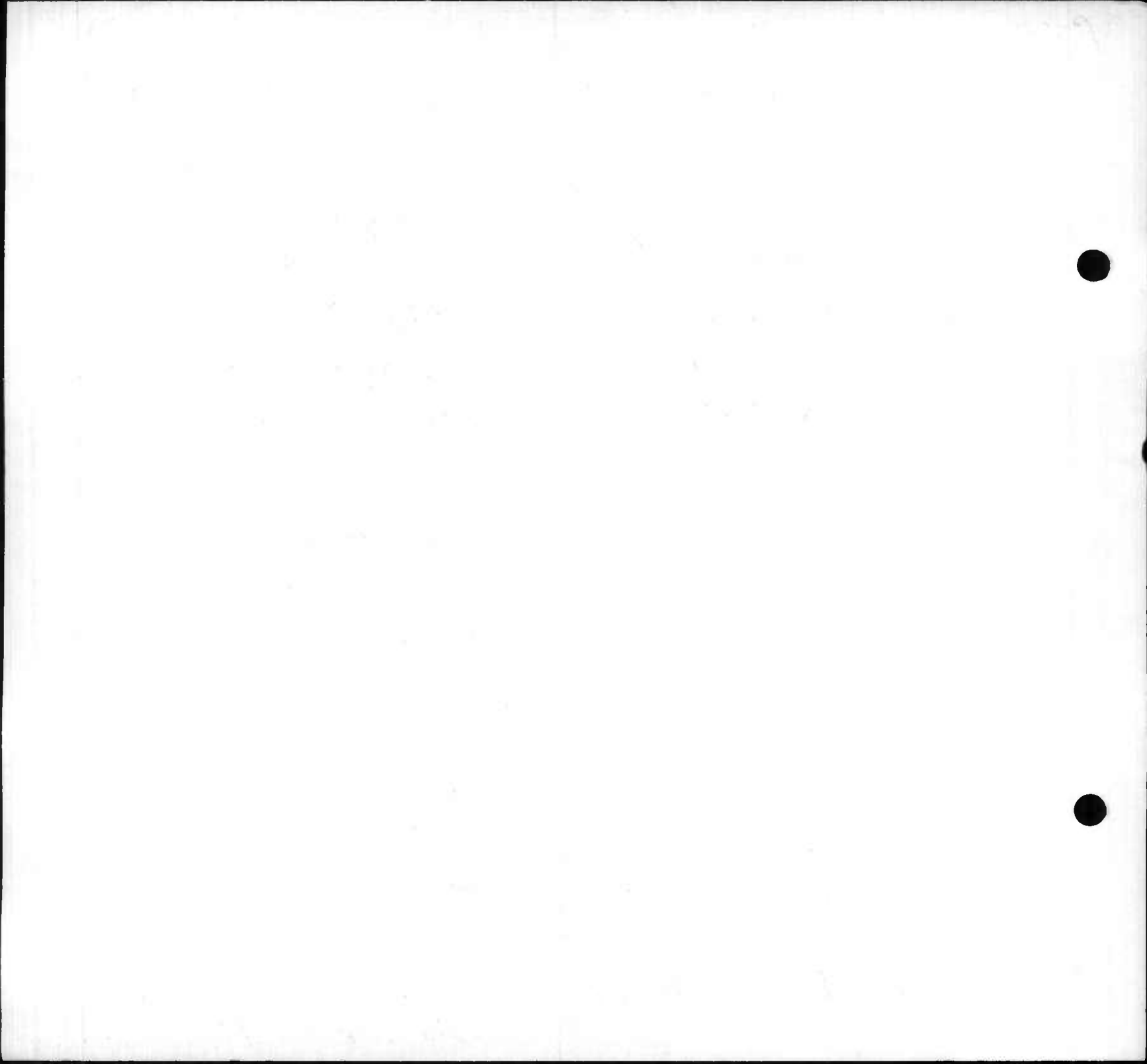
BIRTH NO. 72 07769

1. NAME OF DECEASED (Type or Print) EDWARD OFFER		2. DATE AND HOUR OF DEATH AUGUST 2, 1972 11:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MD. B. COUNTY 1203	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITAL 4940 Eastern Avenue 21224		C. CITY OR TOWN BALTIMORE	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male 6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6-15-90		9. AGE (In years last birthday) 82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY National Co	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN OFFER		14. MOTHER'S MAIDEN NAME DORCAS Harri	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 216-105322	
17. INFORMANT VIOLA OFFER		ADDRESS 2821 GUILFORD.	
18. 153.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HYPERKALEMIA		1 DAY	
(B) DUE TO, OR AS A CONSEQUENCE OF: POSSIBLE CA OF ASCEND. COLON,			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2-2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If medical examiner examined) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from 7-22 19 72 to 8-2 19 72 that (I) (we) last saw the deceased alive on 8-2 19 72 and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Frank Meronk		23B. DATE SIGNED 8-2-72	
23C. PHYSICIAN'S NAME (Type) FRANK MERONK		23D. ADDRESS 4940 Eastern Avenue 21224 BALTIMORE CITY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-8-72	
24C. NAME of CEMETERY or CREMATORY MT. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Westport, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1972		25B. NAME OF REGISTRAR Milton E. Erickson	
25C. FUNERAL DIRECTOR Milton E. Erickson		ADDRESS 1139 N. Cardine St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07770		BALTIMORE CITY HEALTH DEPARTMENT		72 07770	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>JOSEPH ANNICK Jr.</u>		2. DATE AND HOUR OF DEATH <u>8-14-72</u> <u>1:30 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2831</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL OF BALTIMORE</u> <u>42</u>		C. CITY OR TOWN <u>BALTIMORE.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>5511 LYNVIEW AVE 21214</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-25</u>	9. AGE (in years last birthday) <u>47</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant Seaman</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>Joseph Pinnick</u>		14. MOTHER'S MAIDEN NAME <u>Joanna Williams</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W.II</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Meredith Pennick</u> ADDRESS <u>5511 LYNVIEW AVE</u>	
18. <u>4235 X I</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>ATRIAL FIBRILLATION</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CARDIO MYOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>OBSTRUCTIVE LUNG DISEASE</u>		<u>10 DAYS</u> <u>24</u> <u>670 MONTHS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CHRONIC PSYCHOSIS</u>		<u>5 YEARS</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-8</u> 19 <u>72</u> to <u>8-14</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8-14</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>8-14-72</u>		23C. PHYSICIAN'S NAME (Type) <u>LEIF PARKER MD</u>	
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-17-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Arbutus, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>	
25C. FUNERAL DIRECTOR <u>5111 N. T. Funeral Home - CAROLINE</u>		25D. ADDRESS <u>1129 N. CAROLINE</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07771	
BIRTH NO. 72 07771				STATE OF MARYLAND - DHMH	
1. NAME OF DECEASED (Type or Print) <u>Smith, Charles</u>			2. DATE AND HOUR OF DEATH <u>11 August 1972</u> <u>8:00 pm</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 University Hosp</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1101</u>		
5. SEX <u>M</u>			6. RACE <u>B</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>7-30-30</u>			9. AGE (In years last birthday) <u>41</u>		10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ANSON CO N.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Willie J. Wall</u>		
14. MOTHER'S MAIDEN NAME <u>Aurelia Smith</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Aurelia Smith Wadsworth N.C.</u>		
18. <u>322X</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 1. This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Chronic Subdural Empyema</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>6-30-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>SUBDURAL EMPYEMA</u>		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinite medical examined)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from <u>6-22-72</u> 19 <u>72</u> to <u>11 Aug</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>11 Aug</u> 19 <u>72</u> and that (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. A. Rashti M.D.</u> DEGREE				23B. DATE SIGNED <u>11 Aug 72</u>	
23C. PHYSICIAN'S NAME (Type) <u>R. A. Rashti</u> DEGREE				23D. ADDRESS <u>22 So Greene St</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>8/10/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Hendonson Gr Bury Wadsworth NC</u>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1972</u>			
25B. NAME OF REGISTRAR <u>Wadsworth</u>		25C. FUNERAL DIRECTOR <u>Wadsworth</u> ADDRESS			

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72 07772 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07772

BIRTH NO.

1. NAME OF DECEASED (Type or Print) L. JULIA BROOKS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 4015 Belle Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 13 1972 4:10p M.	
6. SEX female		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 8-1-01		10. AGE (In years lost birthday) 71 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Mills		14. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Md. B. COUNTY 1510	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Mary Cooper	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Elaine Curley 4015 Belle Ave.		ADDRESS	
19. 712.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) PARTIAL			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. M.D. EXAMINER'S NAME (Type) DATE SIGNED 8-14-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-17-72	
24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972		25B. NAME OF REGISTRAR Sidney M. Gordon	
25C. FUNERAL DIRECTOR Wm C March 928 E North Ave.		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 07773</u>	
R-200 <u>72 07773</u>				STATE OF MARYLAND - DEPT	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>RICE ALBERT</u>				2. DATE AND HOUR OF DEATH <u>8-12-72</u> <u>1</u> <u>2</u> <u>4</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md</u> B. COUNTY <u>1502</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital of Maryland</u> <u>46</u>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>NEGRO</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>4-20-1912</u> 9. AGE (In years last birthday) <u>60</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electronic Tester, Westinghouse</u>				11. BIRTHPLACE (State or foreign country) <u>Laurens SC</u>	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Rice</u>				14. MOTHER'S MAIDEN NAME <u>Sula parker</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WTI</u>				16. SOCIAL SECURITY NO. <u>249-05-6856</u>	
17. INFORMANT <u>Josephine B Rice</u>				ADDRESS <u>1427 N Fulton Ave</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>43691</u> <u>CVA (L)</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-10-1972</u> to <u>8-12-1972</u> that (I) (we) last saw the deceased alive on <u>8-12-1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. H. Siddiqui</u> M.D. DEGREE				23B. DATE SIGNED <u>8-12-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. H. Siddiqui</u> M.D. DEGREE				23D. ADDRESS <u>Lutheran Hospital of Maryland</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>13 8/19/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Family plot</u>	
24D. LOCATION (City, town, or county) <u>Laurens SC</u>		24E. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1972</u>		24F. NAME OF REGISTRAR <u>Josephine B Rice</u>	
24G. FUNERAL DIRECTOR <u>Josephine B Rice</u>		24H. ADDRESS <u>2222 W North Ave</u>		24I. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1972</u>	



STATE OF MARYLAND-DEMM BALTIMORE CITY HEALTH DEPARTMENT									
72 07774 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					72 07774 REG. NO.				
1. NAME OF DECEASED (Type or Print) BARBARA D. FAULKNER					2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital					3. DATE PRONOUNCED DEAD Month Day Year Hour 8 13 1972 10:50 a.m.				
6. SEX female					7. RACE white				
8. B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTO C. CITY OR TOWN Arbutus D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
9. DATE OF BIRTH 5/17/1972					10. AGE (In years last birthday) 32				
11. BIRTHPLACE (State or foreign country) Anne Arundel Cty. Md.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Bernard Q. Faulkner, Jr.					14. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) None				
15. MOTHER'S MAIDEN NAME Noreen V. Schoene					16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				
17. SOCIAL SECURITY NO. None					18. INFORMANT Bernard Q. Faulkner, Jr. ADDRESS (Same)				
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Sudden Death in Infancy ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
20A. DATE OF OPERATION 2					20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
21. AUTOPSY? (Yes or No) yes					22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
22F. HOW DID INJURY OCCUR?					23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Marvin S. Platt</i> M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. DATE SIGNED 8-14-72				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 8/16/72				
24C. NAME OF CEMETERY or CREMATORY Loudon Park					24D. LOCATION (City, town, or county) (State) Baltimore Md.				
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972					25B. NAME OF REGISTRAR Sidney J. Houston				
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212					ADDRESS				

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>72-11514 72 07775</u> CERTIFICATE OF DEATH				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 07775</u>	
1. NAME OF DECEASED (Type or Print) JENNIFER MARIE LILIEN				2. DATE AND HOUR OF DEATH 08-13-72 5:15 A.M.		STATE OF <u>MARYLAND</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1201</u>			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3706 N. CHARLES STREET							
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08-04-72	9. AGE (In years last birthday) 8	If Under 1 Yr. Months: Days: 8	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) SINAI HOSPITAL BALTIMORE, MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LANCE H. LILIEN				14. MOTHER'S MAIDEN NAME JOANNE M. NILES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Lance H. Lilien 3706 N. Charles St.			
18. 746.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE Pericardial: pulmonary embolism (B) DUE TO, OR AS A CONSEQUENCE OF: Coronary Artery Disease (C) DUE TO, OR AS A CONSEQUENCE OF: For correcting TGV				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 8/12		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Transposition of Great vessels		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from Aug 95 19 72 to Sept 13 19 72 that (X) (we) last saw the deceased alive on Aug 13 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Michael J. Zinner MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/13/72	
23C. PHYSICIAN'S NAME (Type) MICHAEL J. Zinner MD				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-16-72		24C. NAME of CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972		25B. NAME OF REGISTRAR Didough...		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 7405 York Road Balto., Md. 21212			

CONFIDENTIAL

NEW ILLINOIS WHITE LILICH

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TIMORE

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WHITE

ST. LOUIS HOSPITAL

ST. LOUIS, MO.

JOHN R. LILICH

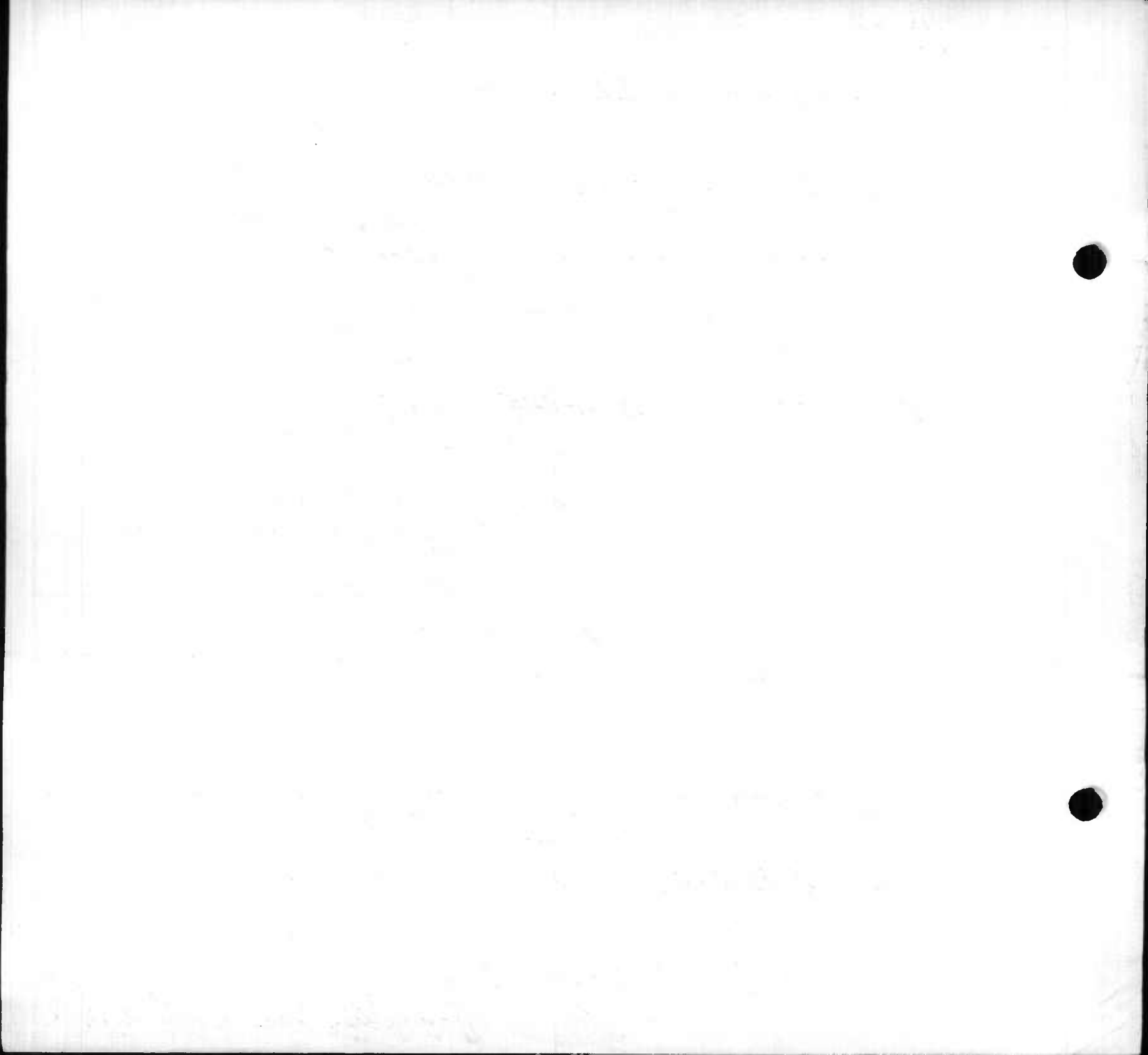
LANCE R. LILICH

YES

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M-520		72 07776		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07776	
1. NAME OF DECEASED (Type or Print) Minke, Emma Elizabeth				2. DATE AND HOUR OF DEATH 8/11/72 2:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY of MARYLAND Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Allegany 5100			
				C. CITY OR TOWN Cumberland		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 424 Bowling Ave Bowling Green			
5. SEX F	6. RACE CAUC.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/6/21	9. AGE (In years last birthday) 51	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY CELANES Fibre Co.		11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl Schung				14. MOTHER'S MAIDEN NAME MAUDE GROWE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 175-14-5615		17. INFORMANT CHART			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 441.1 I [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). pos serology				CAUSE OF DEATH operative death LEFT VENTRICULAR FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ascending Aortic Aneurysm			
				(B) Ascending Aortic Insufficiency (secondary) DUE TO, OR AS A CONSEQUENCE OF: —			
				(C) —			
19A. DATE OF OPERATION 8/11/72				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic Aneur. - AI		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/3 19 72 to 8/11 19 72 that (I) (we) last saw the deceased alive on 8/11 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John R. Sattenfield Jr. MD				23B. DATE SIGNED 8/11/72		23C. PHYSICIAN'S NAME (Type) John R. Sattenfield Jr. MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8/14/72		24C. NAME OF CEMETERY OR CREMATORY St. Mary's Cem.	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972				25B. NAME OF REGISTRAR —		25C. FUNERAL DIRECTOR Boonstetter Inc. Cumb! MD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-653		BALTIMORE CITY HEALTH DEPARTMENT	
72 07777		REG. NO. 72 07777	
CERTIFICATE OF DEATH		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <u>Trent, Daisy Mae</u>		2. DATE AND HOUR OF DEATH <u>8/10/72</u> <u>1745</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Int Sinai Nursing Home</u> <u>4613 Park Heights Avenue</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2798</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3705 Beechler Avenue</u>	
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-3-83</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Eastern, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>192-26-9189</u>	17. INFORMANT <u>Audrey Trent</u> ADDRESS <u>2212-McCulloh St</u>
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Cardio-</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A). <u>Chlorz 1972 Reg amputation</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Vascular Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
19A. DATE OF OPERATION <u>Aug 2 1972</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Leg amputation</u>	20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 4</u> 19 <u>72</u> to <u>Aug 10</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Aug 10</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Louis T. Lavy M.D.</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED <u>Aug 14 - 1972</u>
23C. PHYSICIAN'S NAME (Type) <u>LOUIS T. LAVY M.D.</u>		23D. ADDRESS <u>3502 W. Rogers Ave Baltimore Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>8-15-72</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem</u>	24D. LOCATION (City, town, or county) (State) <u>Ba Itz, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 15 1972</u>		25B. NAME OF REGISTRAR <u>Audrey Trent</u>	25C. FUNERAL DIRECTOR <u>MORTON AND DYETT</u> ADDRESS <u>1701 LAURENS ST. BALT., MD.</u>

Abstract of the

Report of the

Committee

on the

subject of the

Report of the

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> M-630 72 07778 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH REG. NO. 72 07778 STATE OF MARYLAND-DH&H </div>			
1. NAME OF DECEASED (Type or Print) EUGENE MERRITT		2. DATE AND HOUR OF DEATH August 12, 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3513 Haywood Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2788 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3513 Haywood Avenue	
5. SEX MALE	6. RACE BLACK	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/1903
9. AGE (In years last birthday) 69		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Eugene Merritt, Sr.	
14. MOTHER'S MAIDEN NAME Annette Merritt		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Theresa Merritt 3513 Haywood Avenue	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I 410.9 I II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: M-9. (B) DUE TO, OR AS A CONSEQUENCE OF: ASCV (C) Coronary artery disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1970 to 7/15/72 , that (I) (we) last saw the deceased alive on 7/15/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE WILFSON		23B. DATE SIGNED 8/14/72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 5221 York Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/72	
24C. NAME OF CEMETERY or CREMATORY Carver Memorial Park		24D. LOCATION (City, town, or county) (State) Laurel, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972		25B. NAME OF REGISTRAR Shirley J. Heston	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens Street	

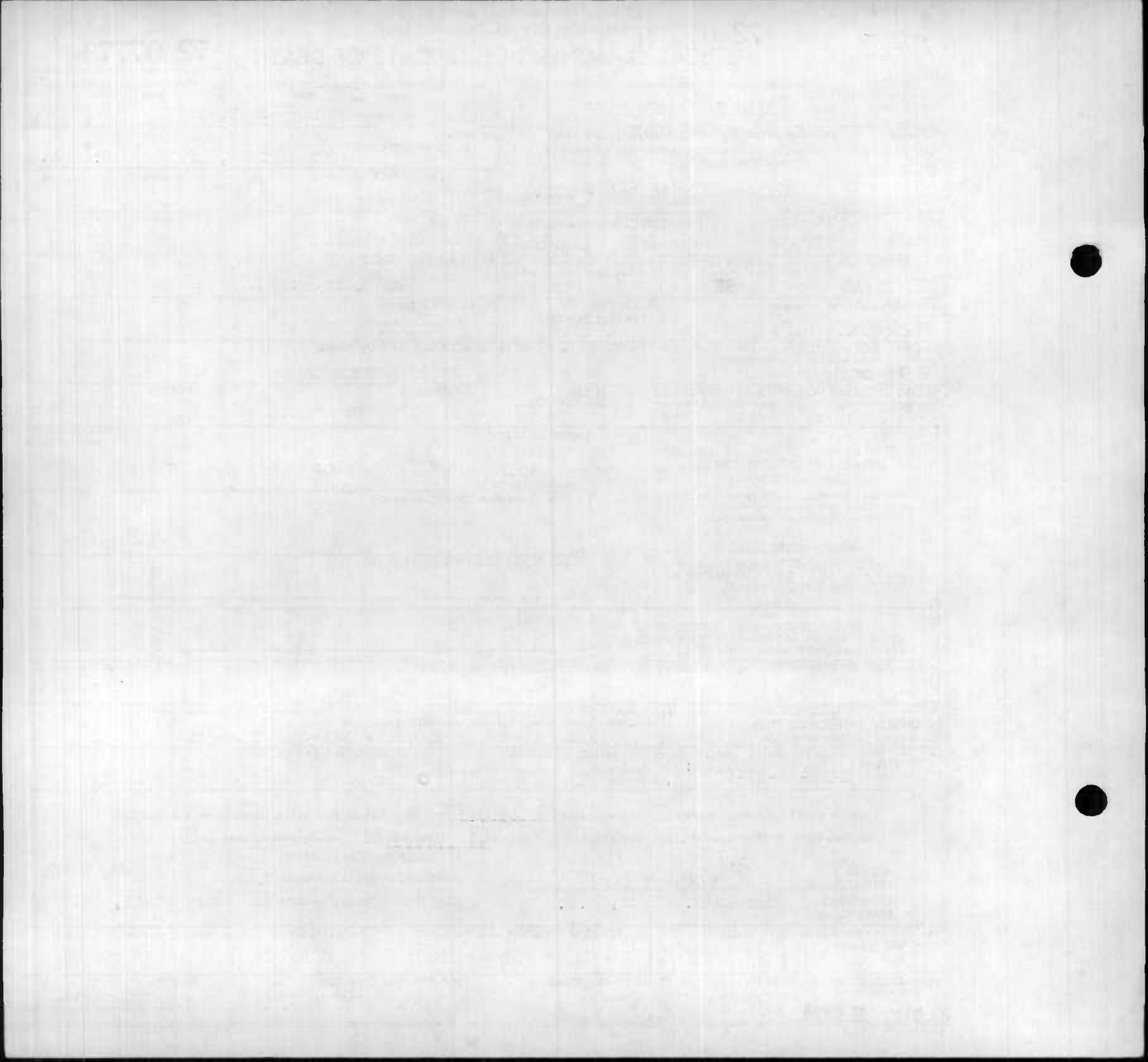


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES BANNERMAN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 12, 1972	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year August 12, 1972 2:06 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY 1605	
9. DATE OF BIRTH 12/25/16		10. AGE (in years lost birthday) 55	
11. BIRTHPLACE (State or foreign country) Rocky Mt., N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alex Bannerman		14. MOTHER'S MAIDEN NAME Janie Bannerman	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5/14/43-11/15/45		18. SOCIAL SECURITY NO. 218-03-4347	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wounds of chest and abdomen (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) Bar	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Lanvale & Payson Streets		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 8-12-72 1:55 A.M.	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Owner of bar shot during robbery	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 12, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/72	
24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 15 1972		25B. NAME OF REGISTRAR A. J. [Signature]	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		25D. ADDRESS 1701 Laurens Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07780	
G-615 72 07780				CERTIFICATE OF DEATH	
BIRTH NO.		STATE OF MARYLAND-DEMENT		72 07780	
1. NAME OF DECEASED (Type or Print) AUGUSTUS GARVINS (GARVINS)		2. DATE AND HOUR OF DEATH August 10, 1972 7:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 39 Quoniam Hospital		4. USUAL RESIDENCE (Where deceased lived, II institution; residence before admission) A. STATE MARYLAND B. COUNTY 1501			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Quoniam Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2600 Liberty Height Ave. Baltimore, Md. 21215		C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1811 N. MONROE ST.			
5. SEX F	6. RACE B	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-11	9. AGE (In years last birthday) 60 yrs.	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) VIRGINIA, Portsmouth	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME " Huffman		14. MOTHER'S MAIDEN NAME Lucretia Williams	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MR. SIDNEY GARVINS SAME (HUSBAND)	
18. 41221		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Subarachnoid Hemorrhage		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF:			
		(C) Stroke			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-7 19 72 to 8-10 19 72 that (I) (we) last saw the deceased alive on 8-10 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Virginia Lauro-Mercado		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-10-72	
23C. PHYSICIAN'S NAME (Type) VIRGINIA F. MERCADO, M.D.		23D. ADDRESS Quoniam Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/72		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE RECD. BY HEALTH DEPT. AUG 15 1972		25B. NAME OF REGISTRAR MORTON S. Dyer	
25C. FUNERAL DIRECTOR Dyett F.H.		ADDRESS 1701 Laurens St.			

OFFICE OF THE
SHERIFF
COUNTY OF LOS ANGELES

Letter No.

Received of
Honor
\$100.00
for
Fidelity Bond

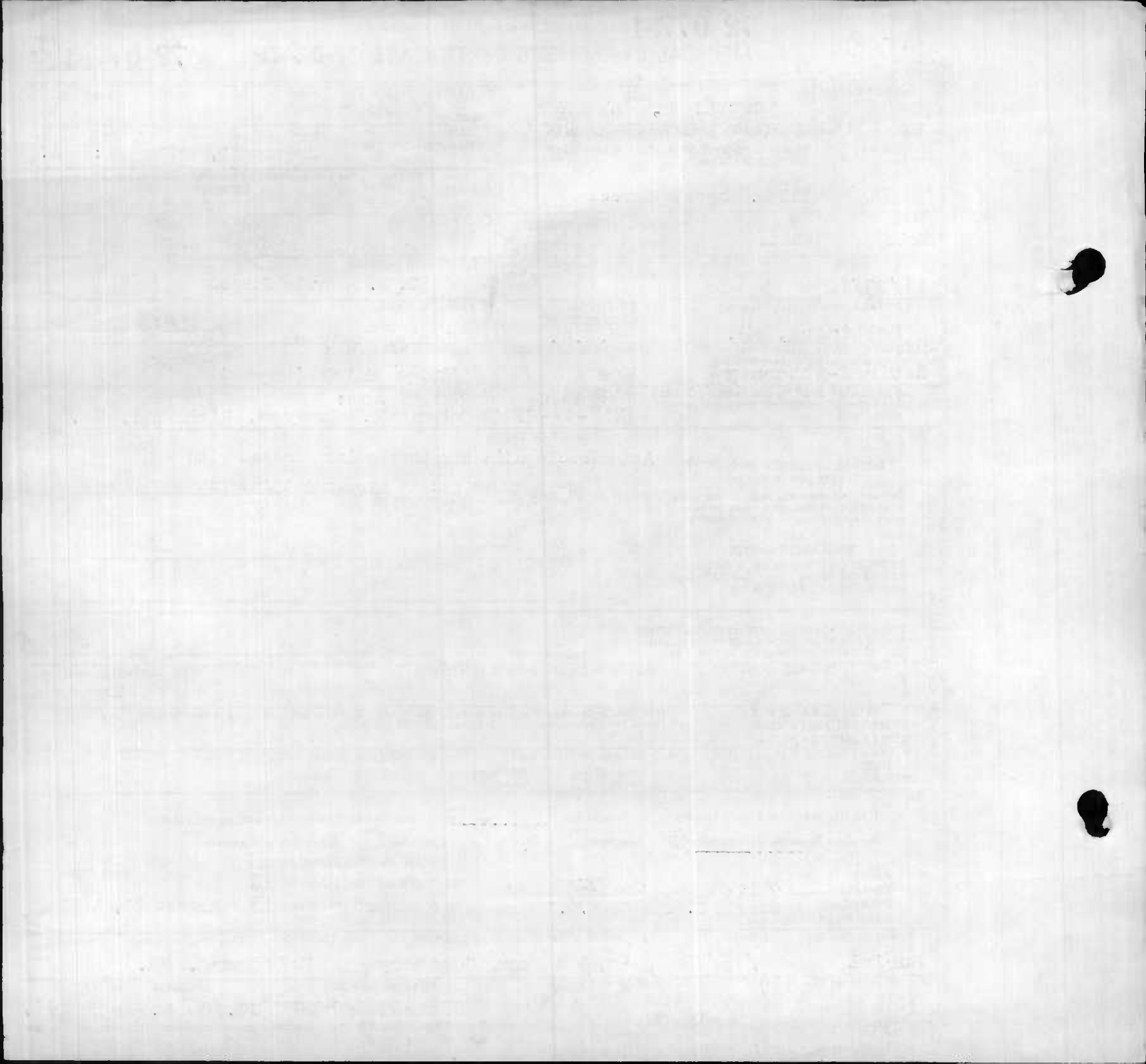
Amount paid to
Fidelity Bond Co.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07781

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		ROBERT H. LOHMEYER		2. DATE OF DEATH		Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		122 W. Lanvale Street		3. DATE PRONOUNCED DEAD		August 12, 1972 6:45 A.	
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN	
Male		White				Baltimore	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
11/23/12		59		Baltimore, Md.		U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. KIND OF BUSINESS OR INDUSTRY		16. FATHER'S NAME		17. MOTHER'S MAIDEN NAME	
Retired-Attorney		Law		Carl Lohmeyer		Madge White (Whyte)	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		19. SOCIAL SECURITY NO.		20. INFORMANT		21. ADDRESS	
		217-07-2217		son: Robert H. Lohmeyer, Richmond, Va.			
19. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Arteriosclerotic cardiovascular disease with		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE recent myocardial infarct			
				DUE TO, OR AS A CONSEQUENCE OF:			
		ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)			
		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)			
2				Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?			
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
23.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		Marvin S. Platt, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		August 12, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/15/72		Loudon Park Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 16 1972				STEWART & MOWEN CO.		21201 108 W. North Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-135		72 07782		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07782	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEMH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		TIPTON Mr. CARL		8/6/72		2:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME and Hospital (separated)				A. STATE Maryland			
				B. COUNTY BALTO			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 6515 HELENA AVE			
5. SEX M	6. RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/5/1920		9. AGE (In years last birthday) 52 yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl Tipton				14. MOTHER'S MAIDEN NAME MARIE BLACKSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) unknown		16. SOCIAL SECURITY NO. 219-05-9807		17. INFORMANT SELF		ADDRESS	
18. 575X1-250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ch. Cholecystitis, Diabetic S. (B) DUE TO, OR AS A CONSEQUENCE OF: Peptic ulcer. (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 8/2/1972		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ch. Cholecystitis + duodenal ulcer		20A. AUTOPSY? (Yes or No) Pending		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from: 6-9-72 19 to 8/6 1972 that (II) (we) lost saw the deceased alive on 8/6 2:30 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE G. GURUSWAMY, M.D.				23B. DATE SIGNED 8/6/72		23C. PHYSICIAN'S NAME (Type) G. GURUSWAMY, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-10-1972		24C. NAME of CEMETERY or CREMATORY St. Marks Cemetery		24D. LOCATION (City, town, or county) (State) Perryville, Cecil, Maryland.	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR ADDRESS Lee A. Patterson & Sons, Perryville, Md.			

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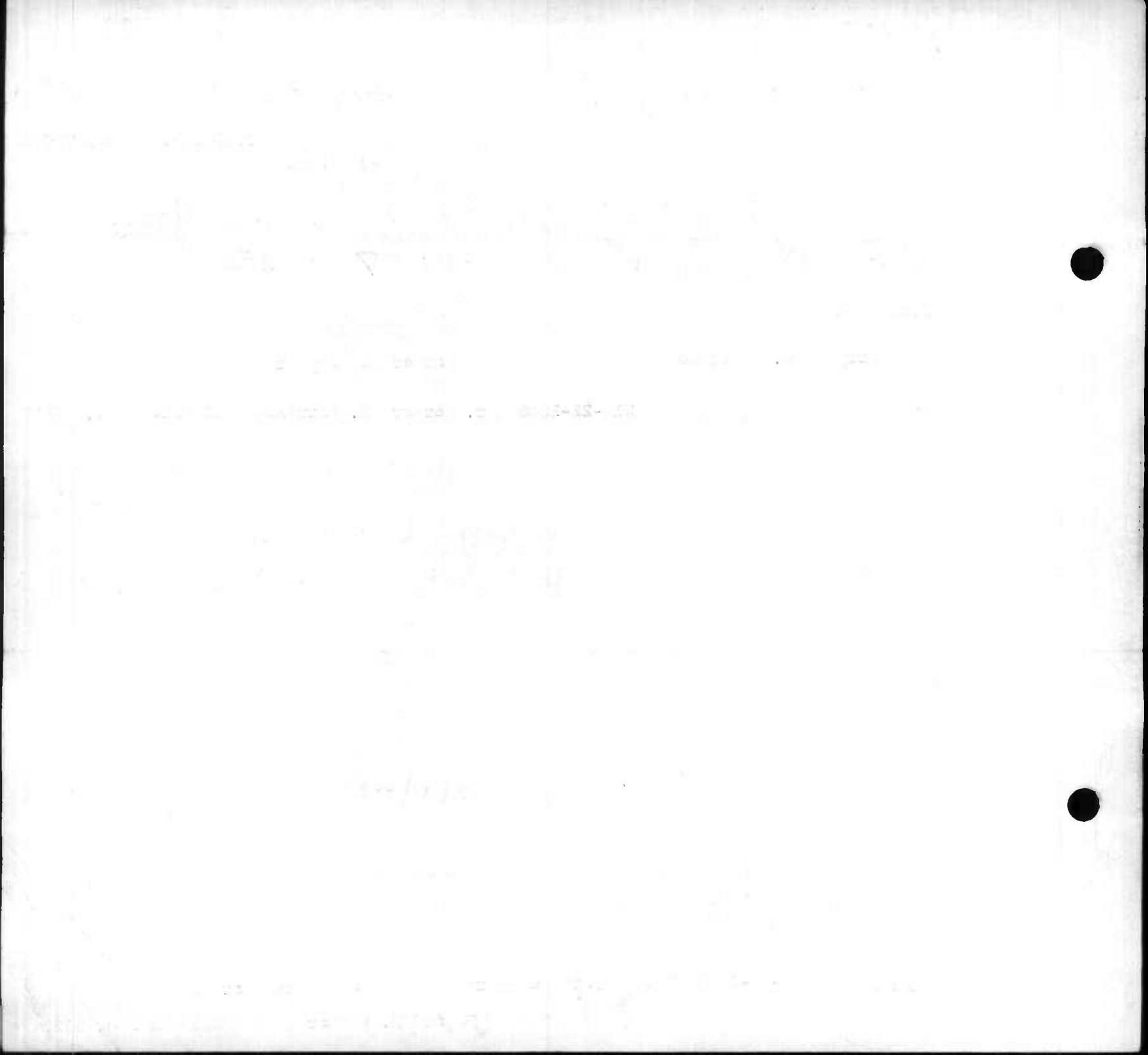
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 07783 STATE OF MARYLAND-DEME	
BIRTH NO. K-455		72 07783		2. DATE AND HOUR OF DEATH August 11, 1972 1:45P.M.	
1. NAME OF DECEASED (Type or Print) Killmon, Mary V.		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE B. COUNTY MARYLAND, XXXXXXXX. BALTIMORE			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital of MD.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8-19-07		9. AGE (in years last birthday) 64		10. AGE (in years last birthday) 65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harry S. Mettee		14. MOTHER'S MAIDEN NAME Katherine Snyder	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-22-2846		17. INFORMANT Mr. Bernard C. Harriss, 3612 Lilac Ave. 21227	
18. I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ADVANCED BRONCHOGENIC CARCINOMA (B) DUE TO, OR AS A CONSEQUENCE OF: Mediastinal metastasis (C) DUE TO, OR AS A CONSEQUENCE OF: Metastatic Liver + malignant cathechixia			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8/1/72 to 8/11/72 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Gunday		23B. DATE SIGNED 8/11/72		23C. PHYSICIAN'S NAME (Type) E. SANDOZ	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-15-1972	
24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972	
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25D. ADDRESS	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07784

1. NAME OF DECEASED (Type or Print) FRANCIS KILMURRY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 517 Cathedral St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 2 1972 1:20 p.m.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 10-22-26		10. AGE (In years, months, days, hours, minutes) 45	
11. BIRTHPLACE (State or foreign country) BALTO. Md.		12. CITIZEN OF WHAT COUNTRY? UNKNOWN	
13. FATHER'S NAME UNKNOWN		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN	
15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) ?	
17. SOCIAL SECURITY NO. 214-10-5425		18. INFORMANT Mr. Carbone - 320 Cathedral St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Marvin S. Platt EXAMINER'S NAME (Type) Marvin S. Platt, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-3-72	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE AUG 4 72	
24C. NAME OF CEMETERY or CREMATORY WOODLAWN		24D. LOCATION (City, town, or county) (State) 2130 WOODLAWN DR BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972		25B. NAME OF REGISTRAR James W. [illegible]	
25C. FUNERAL DIRECTOR 15 RAUSE FUNERAL HOME - S. CHAS. ST		ADDRESS 1216	

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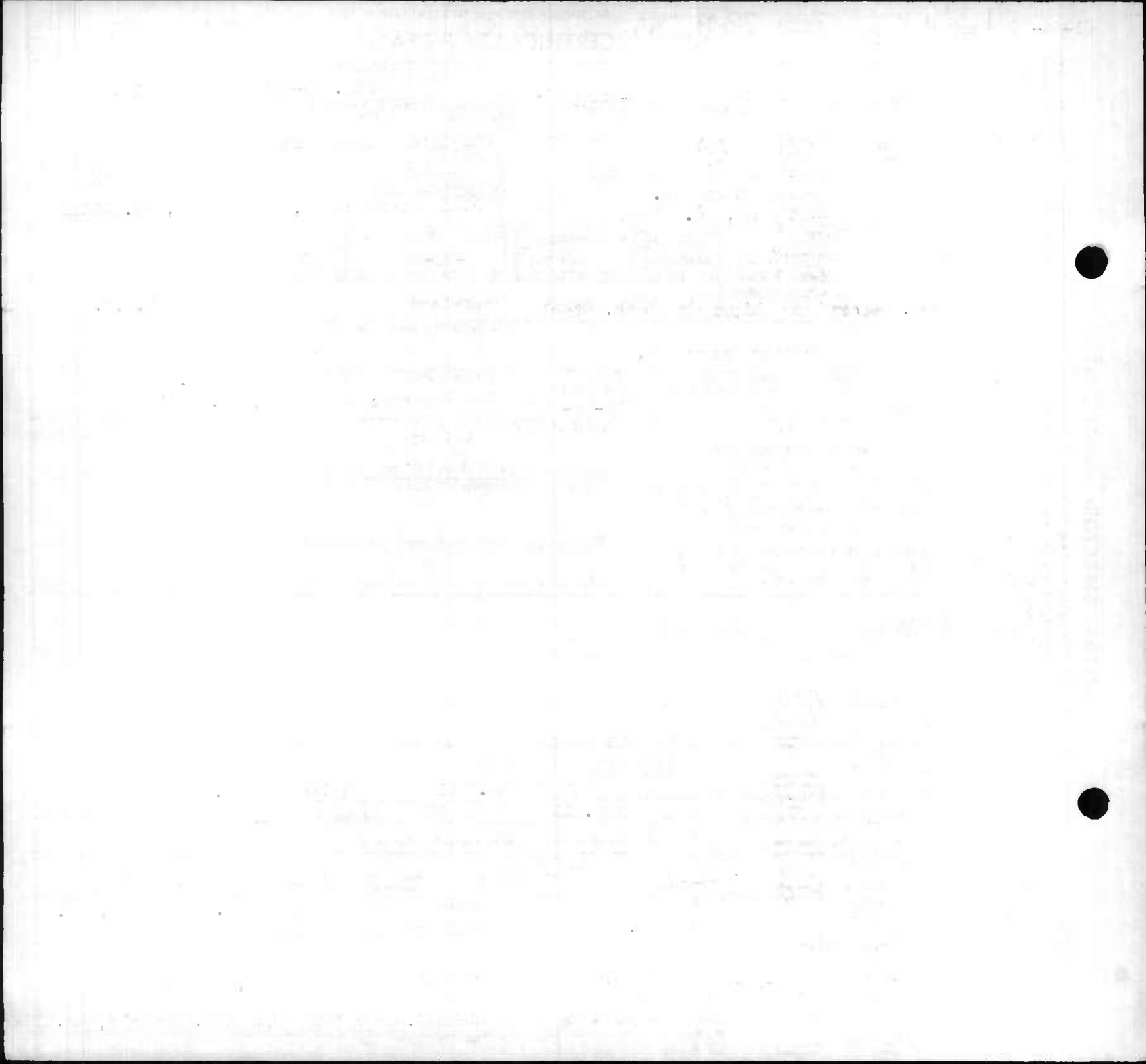
10/10/72

CERTIFICATE OF DEATH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Creston Robert Bearry Jr.		2. DATE AND HOUR OF DEATH Aug. 11-1972 12:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY Maryland Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 31 39 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 2725 Moorgate Rd, Baltimore, Md. 21222					
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-20	9. AGE (In years last birthday) 51	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Acct. Supervisor Shipyards Beth. Steel		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Creston Bearry Sr.		14. MOTHER'S MAIDEN NAME Mary Woodhead			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 214-14-5754		17. INFORMANT 4940 Eastern Ave. ADDRESS BCH Records: Baltimore, Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DOA Pulmonary Embolism 3 hrs.		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 11 19 72 to Aug. 11 19 72 that (I) (we) last saw the deceased alive on Aug. 11 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bernard Slosberg MD		23B. DATE SIGNED 8/11/72			
23C. PHYSICIAN'S NAME (Type) Bernard Slosberg		23D. ADDRESS 4940 Eastern Ave. Baltimore, Md. Baltimore City Hospitals			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-15-72		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Park	
24D. LOCATION (City, town, or county) (State) Dorsey, Maryland					
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972		25B. NAME OF REGISTRAR Audrey Johnston		25C. FUNERAL DIRECTOR John J. Duda 7922 Wise Ave. Dundalk, Md. 21222	

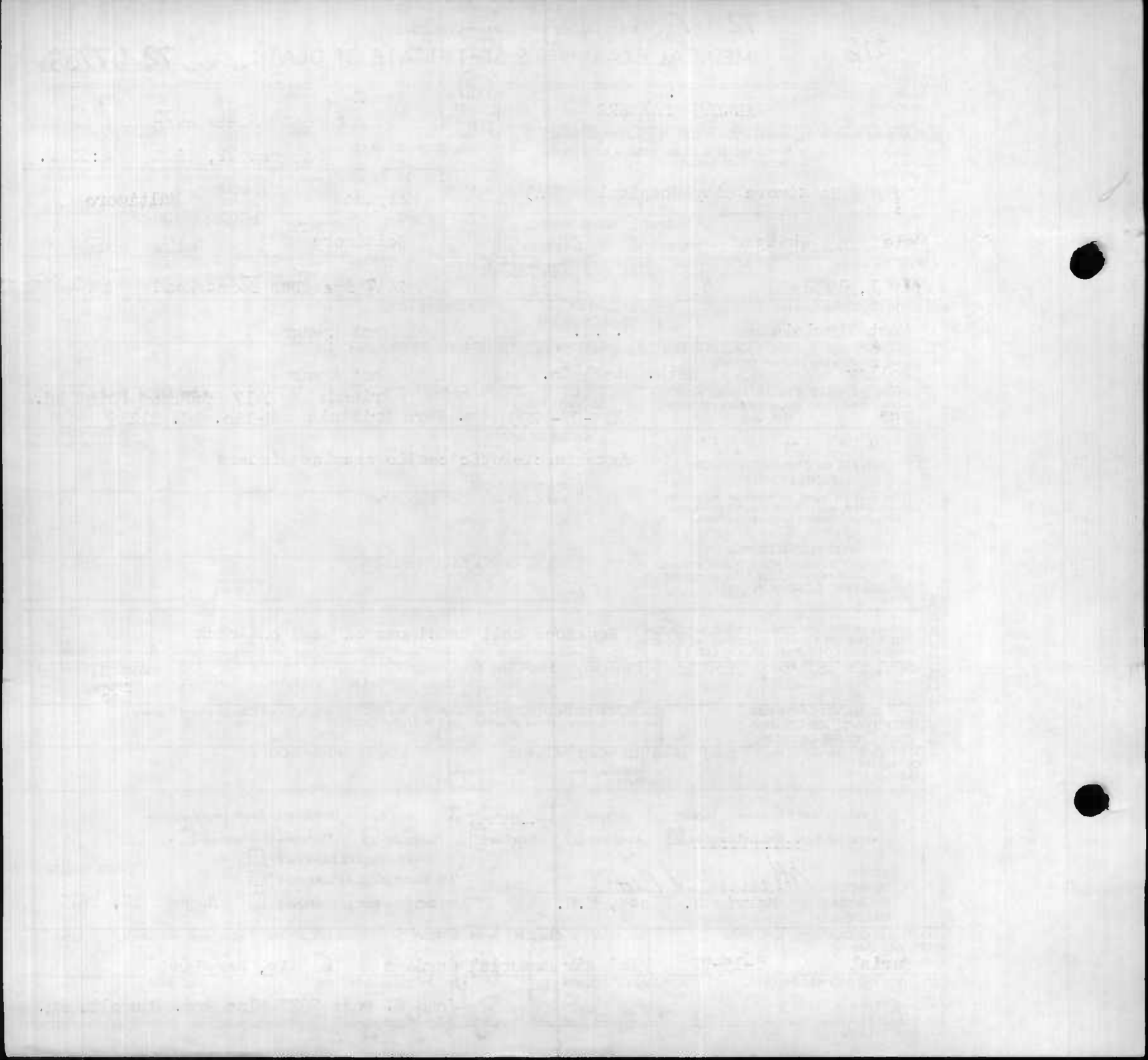


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07786

BIRTH NO.

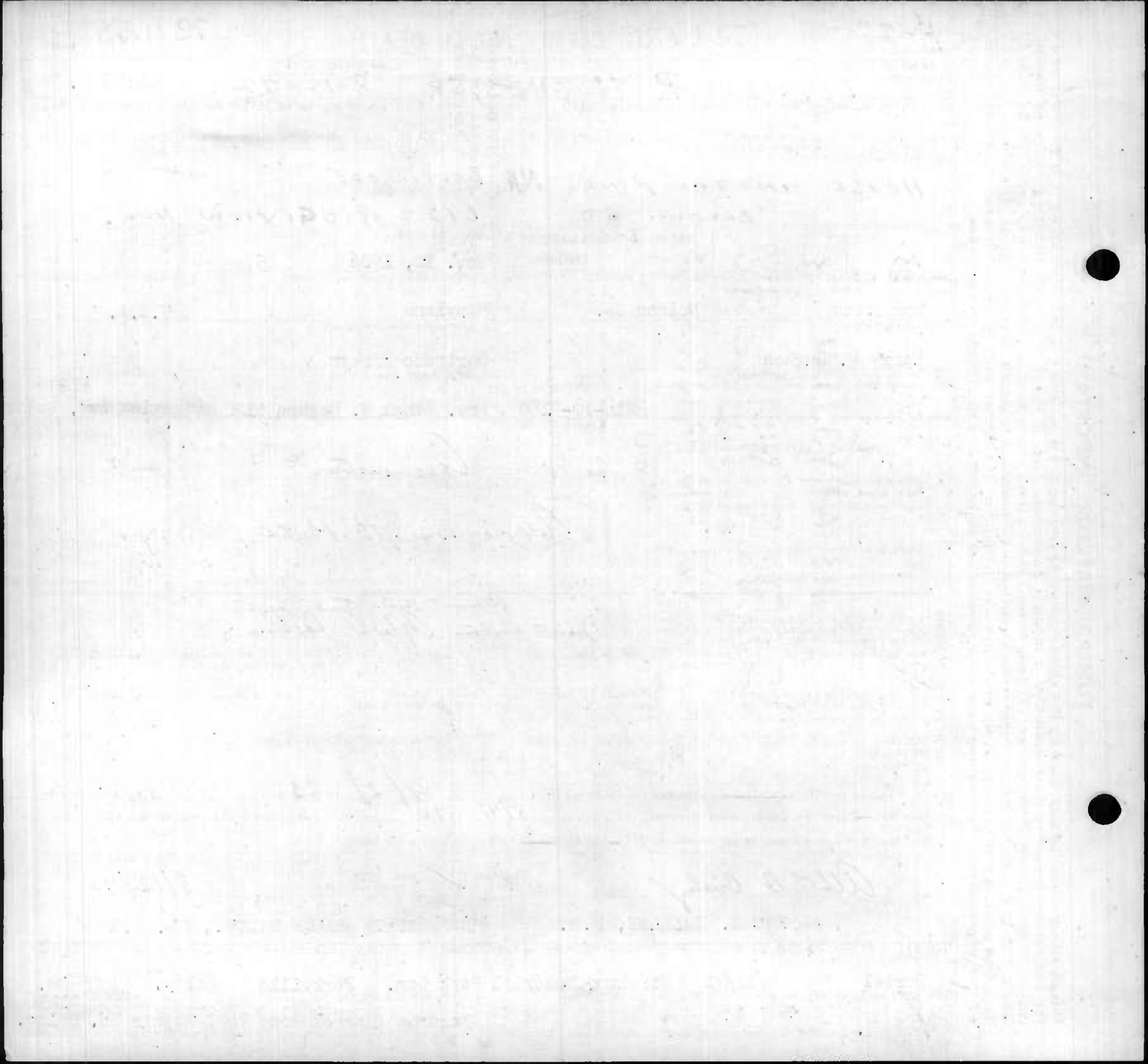
1. NAME OF DECEASED (Type or Print) WILLIAM SAXBERG		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 11, 1972		M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year August 11, 1972		Hour 4:55 P.M.
6. SEX Male		7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH July 1, 1912		10. AGE (in years last birthday) 60	11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME not known		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roller
15. MOTHER'S MAIDEN NAME not known		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) yes WW II		17. SOCIAL SECURITY NO. 213-07-7299
18. INFORMANT Friend: Mr. Fern Brittain		19. ADDRESS 2417 Sparrows Point Rd. Balto. Md. 21219		20. DATE OF OPERATION 8-15-72
21. AUTOPSY? (Yes or No) Yes		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Bel Air Memorial Gardens		23. LOCATION (City, town, or county) (State) Bel Air, Maryland
24. BURIAL CREMATION, REMOVAL (Specify) Burial		25. DATE REC'D BY HEALTH DEPT. AUG 16 1972		26. NAME OF REGISTRAR Signy, [Signature]
27. FUNERAL DIRECTOR John J. Duda		28. ADDRESS 7922 Wise Ave. Dundalk, Md.		29. DATE SIGNED August 12, 1972



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 07787</u>
72 07787 CERTIFICATE OF DEATH				STATE OF MARYLAND - DHMH
BIRTH NO. <u>H-220</u>		1. NAME OF DECEASED (Type or Print) <u>EVERETT P. HUGHES, SR.</u>		
2. DATE AND HOUR OF DEATH <u>8-12-72</u> <u>11:45</u> A. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2734</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>HOUSE IN THE PINES N.H.</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 BELAIR RD</u>		E. STREET AND NUMBER <u>6122 RIDGEVIEW AVE</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10, 1906</u>	9. AGE (In years last birthday) <u>65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Nelson Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Harry W. Hughes</u>		
14. MOTHER'S MAIDEN NAME <u>Gertrude Parker</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>214-10-9180</u>		17. INFORMANT <u>Mrs. Ethel W. Hughes 6122 Ridgeview Ave. Balto</u>		
18. <u>185 X 14 250.9</u>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinomatosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>months</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Adenocarcinoma of the Prostate</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>years</u>
(C) _____				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Recent Urinary Tract Infection</u> <u>Diabetes mellitus</u> <u>Aphasia</u> <u>Cachexia</u>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>4/2/1963</u> to <u>8/12/1972</u> , that (I) (was) lost saw the deceased alive on <u>8/9/1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Albert B. Bradley</u>		23B. DATE SIGNED <u>8/12/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>ALBERT B. BRADLEY, M.D.</u>		23D. ADDRESS <u>4900 BELAIR ROAD BALTO., MD. 21206</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/16/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial Park Cem.</u>
24D. LOCATION <u>Parkville Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 16 1972</u>		
25B. NAME OF REGISTRAR <u>1072000</u>		25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Rd. Balto.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07788		72 07788	
7-260				72 07788		72 07788	
BIRTH NO.				72 07788		72 07788	
1. NAME OF DECEASED (Type or Print) RICHARD E. FISHER				2. DATE AND HOUR OF DEATH AUG. 11, 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO.			
FULL NAME OF HOSPITAL OR INSTITUTION BALTO. CITY HOSP.				C. CITY OR TOWN COLGATE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH JUNE 8, 1925		9. AGE (In years last birthday) 47	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICK LAYER				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME CARL H. FISHER			
14. MOTHER'S MAIDEN NAME EMMA BAUCHMAN				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II			
16. SOCIAL SECURITY NO. 219-16-8398				17. INFORMANT ALVINA FISHER			
18. CAUSE OF DEATH				ADDRESS ABOVE			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 MIN.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension				10 years.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/57 19 to 8/72 19, that (I) (we) last saw the deceased alive on 8/11/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Max Baumann				23B. DATE SIGNED 8/14/72		23C. PHYSICIAN'S NAME (Type) MAX BAUM	
23D. ADDRESS MD. 7422 Eastern Ave Baltimore.				24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 8/15/72				24C. NAME OF CEMETERY OR CREMATORY OAK LAWN		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972				25B. NAME OF REGISTRAR J. G. CONNELLY		25C. FUNERAL DIRECTOR 300 MACE	

CHAS. H. FISHER, JR.

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DATE CITY WEST

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CHAS. H. FISHER, JR.

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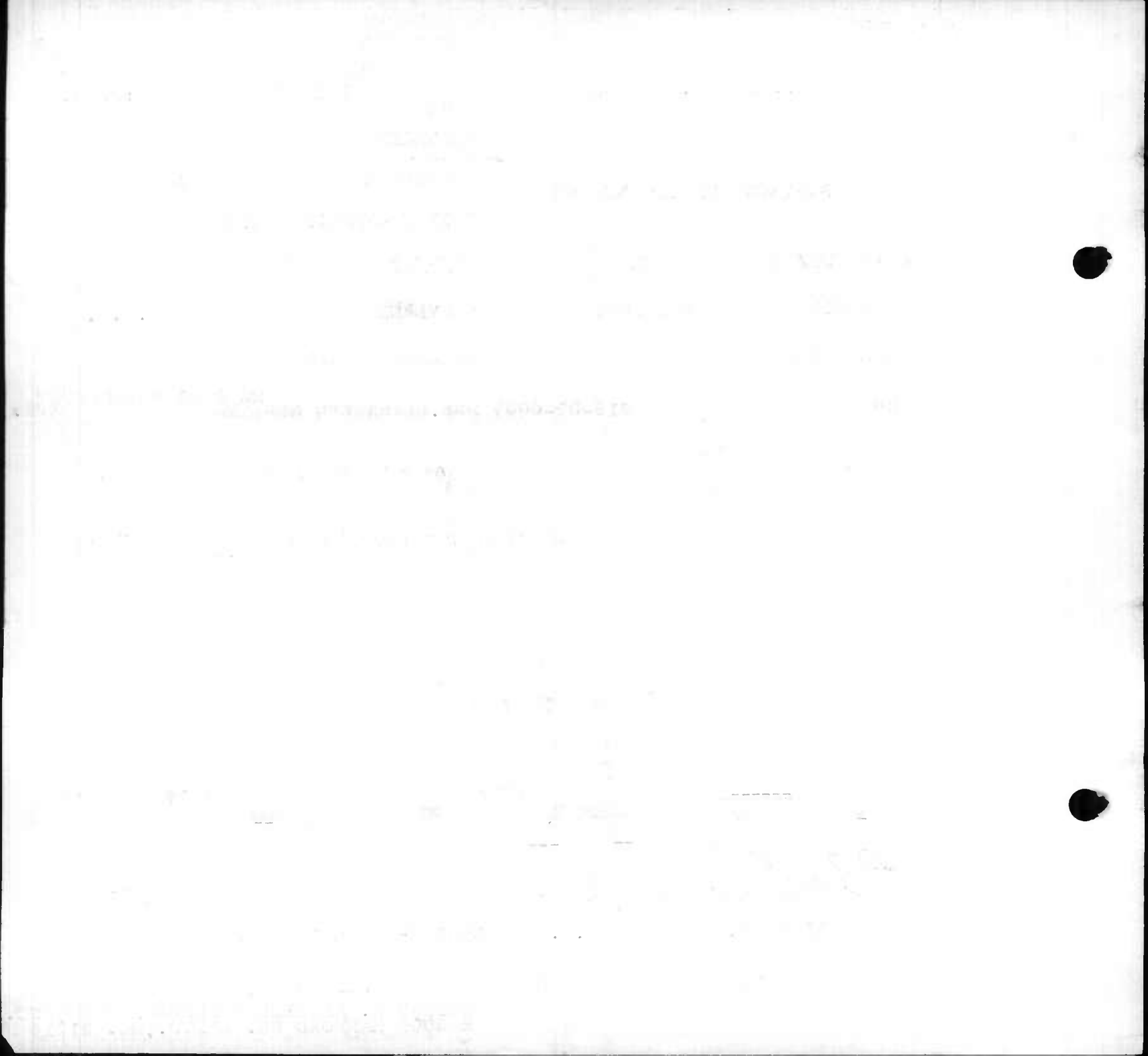
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07789		72 07789	
BIRTH NO.				72 07789		REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		STATE OF MARYLAND - DUMFRIES	
BESSIE F. GUTMAN				8/14/72		10:15 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
00 3731 GREENMOUNT AVENUE				MARYLAND			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				3731 GREENMOUNT AVENUE			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7/3/83	89			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE				OWN HOME		MARYLAND	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?			
JOHN FRIST				U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				215-09-0007		MRS. ELIZABETH MERLING	
18. CAUSE OF DEATH				ADDRESS			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				* 3731 GREENMOUNT AVE.			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE Myocardial infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF:				DUE TO, OR AS A CONSEQUENCE OF:		2 mo.	
ANTECEDENT CAUSES				(B) Arteriosclerotic cardiovascular disease		10 yrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (the hospital) attended the deceased from July 19 70 to August 14 1972							
that (I) (we) last saw the deceased alive on August 3, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Lloyd E. Saylor M.D.				8/15/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
LLOYD E. SAYLOR M.D.				3902 GREENMOUNT AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		8/17/72		LOUDON PARK CEMETERY		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
AUG 16 1972		[Signature]		ROBERT C. ALTENBURG FUNERAL HOME INC.		6009 HARFORD RD. BALTO., MD. 21214	



FUNERAL DIRECTOR: IMPORTANT

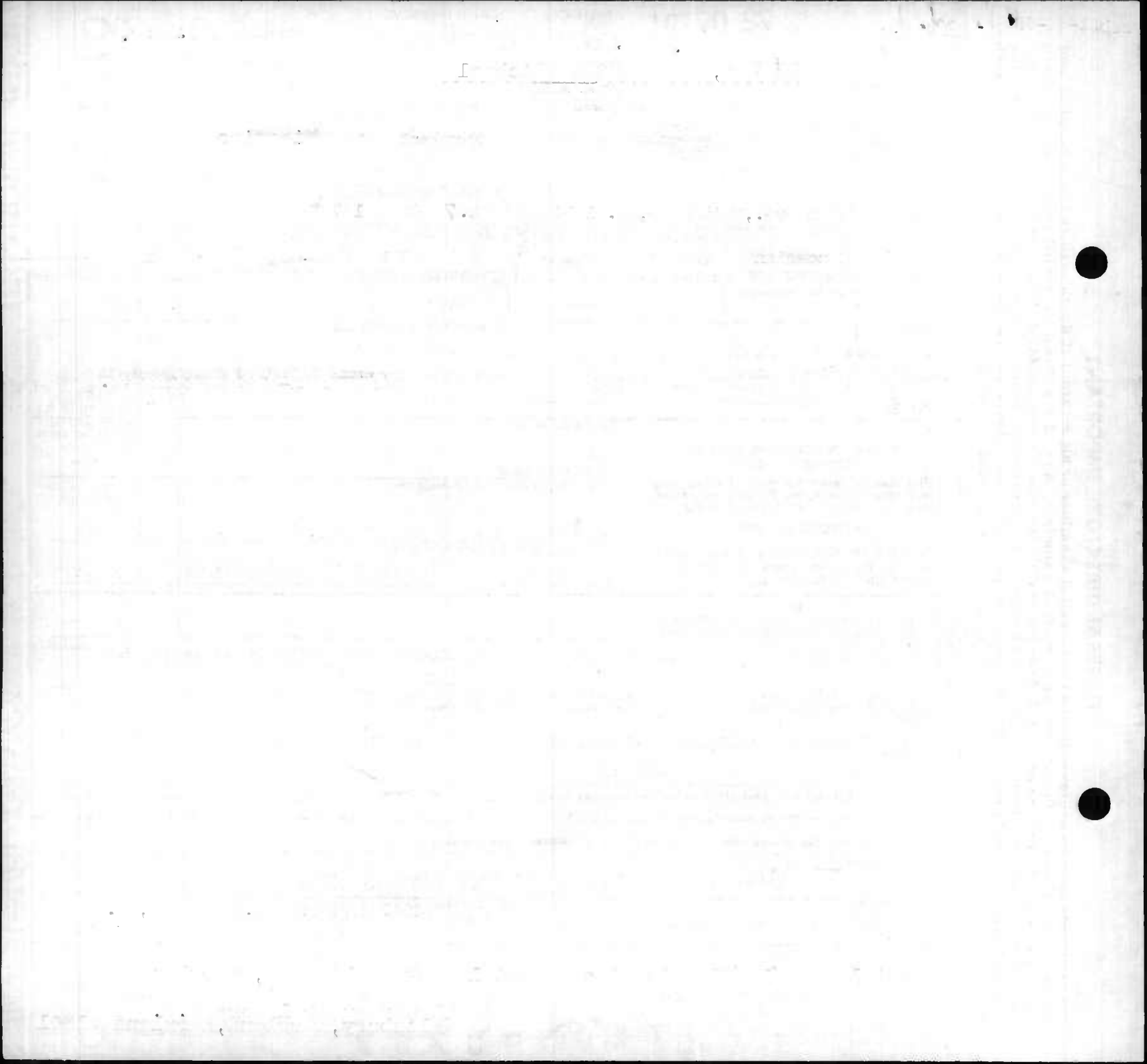
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. <u>72 07730</u>	
B-246 72 07790 CERTIFICATE OF DEATH				STATE OF MARYLAND - DUMM	
1. NAME OF DECEASED (Type or Print) BIXLER, WILBUR OSCAR			2. DATE AND HOUR OF DEATH 8/13/72 8:10PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD BALTIMORE, MARYLAND 21218			A. STATE MARYLAND B. COUNTY BALTIMORE		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN OWINGS MILL D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			E. STREET AND NUMBER 10908 HUNTCLEIFF ROAD		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER			B. DATE OF BIRTH 6-8-13 9. AGE (In years last birthday) 59		
10B. KIND OF BUSINESS OR INDUSTRY Paving			11. BIRTHPLACE (State or foreign country) WESTMINSTER, MARYLAND		
13. FATHER'S NAME Oscar Bixler			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 7-8-42 to 8-13-45			14. MOTHER'S MAIDEN NAME Florence Nusbaum		
16. SOCIAL SECURITY NO. 216-10-68-63			17. INFORMANT ADDRESS CLINICAL RECORDS-VAH BALTIMORE, MD.		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY EMBOLISM			24 hours		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. THROMBOPHLEBITIS					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION NONE			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) YES			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6-30 19 72 to 8-13- 19 72 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 8-13- 19 72 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE Robert E. Greenspan MD			23B. DATE SIGNED 8-14-72		
23C. PHYSICIAN'S NAME (Type) ROBERT E. GREENSPAN, M. D.			23D. ADDRESS VA Hospital, Baltimore, Md. 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE Aug. 17, 1972		
24C. NAME OF CEMETERY OR CREMATORY Meadowbranch Cem.			24D. LOCATION (City, town, or county) (State) Westminster, Carroll, Md.		
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972			25B. NAME OF REGISTRAR Adrian Wharton		
25C. FUNERAL DIRECTOR Eckhardt-King			25D. ADDRESS 21117		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

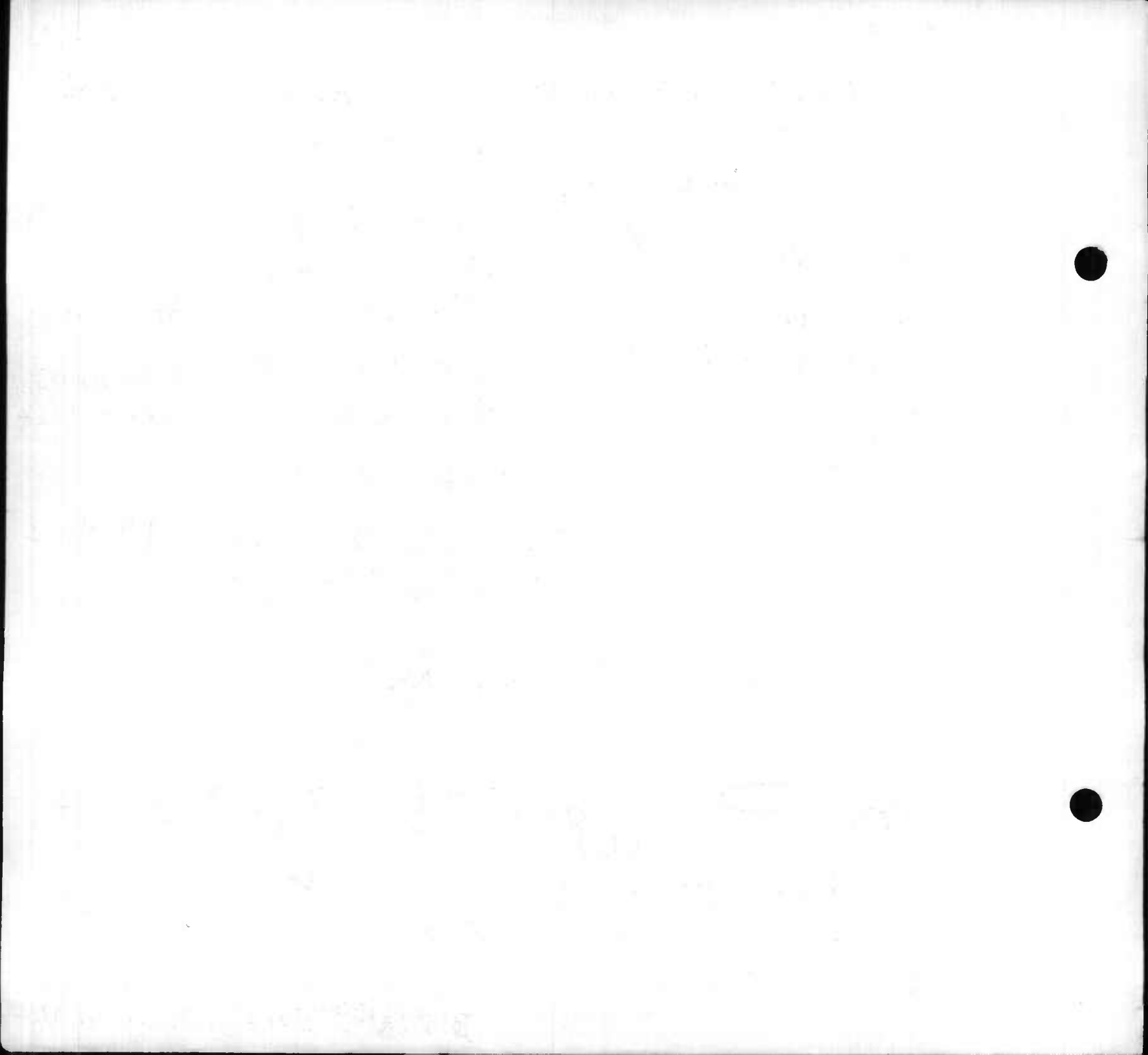
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72.07791	
7-432 72 07791		STATE OF MARYLAND-DEPT	
BIRTH NO. <u>7-432</u>		DATE AND HOUR OF DEATH <u>8/10/72</u> <u>1 6 58</u> A.M.	
1. NAME OF DECEASED (Type or Print) <u>FIELD, TODD Michael</u>		2. DATE AND HOUR OF DEATH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>BALTIMORE CITY HOSPITAL</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Wicomico</u>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>4940 Eastern Ave., Baltimore, Md. 21224</u>		C. CITY OR TOWN <u>SALISBURY</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u> 6. RACE <u>Caucasian</u>		E. STREET AND NUMBER <u>Rt. 7 BX 147 A</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/8/72</u> 9. AGE (in years last birthday) <u>0 2</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLARD WAYNE FIELDS</u>		14. MOTHER'S MAIDEN NAME <u>(SHARON) TODD</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Records: BCH-4940 Eastern Ave. JOSEPH T. MARINO, MD</u>		ADDRESS <u>438 N. CALVERT ST BALTO., MD 21202</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CARDIO RESPIRATORY ARREST	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) RESPIRATORY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF:	
		(C) EXCESSIVE PREMATUREITY (BW 1#13oz)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>8/12/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>2</u>	
20A. AUTOPSY (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (we) (this hospital) attended the deceased from <u>8/8/72</u> to <u>8/10/72</u> and that (we) last saw the deceased alive on <u>8/10/72</u> and that (we) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.			
23A. SIGNATURE <u>Joseph T. Marino MD</u>		23B. DATE SIGNED <u>8/10/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOSEPH T. MARINO, MD</u>		23D. ADDRESS <u>4940 Eastern Ave. Baltimore, Md. 938 N. CALVERT ST BALTIMORE, MD 21202</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/12/72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 16 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Horton</u>	
25C. FUNERAL DIRECTOR <u>Holloway Funeral Home P.A. Salisbury, Maryland</u>		ADDRESS <u>Maryland 21801</u>	



FUNERAL DIRECTOR: IMPORTANT

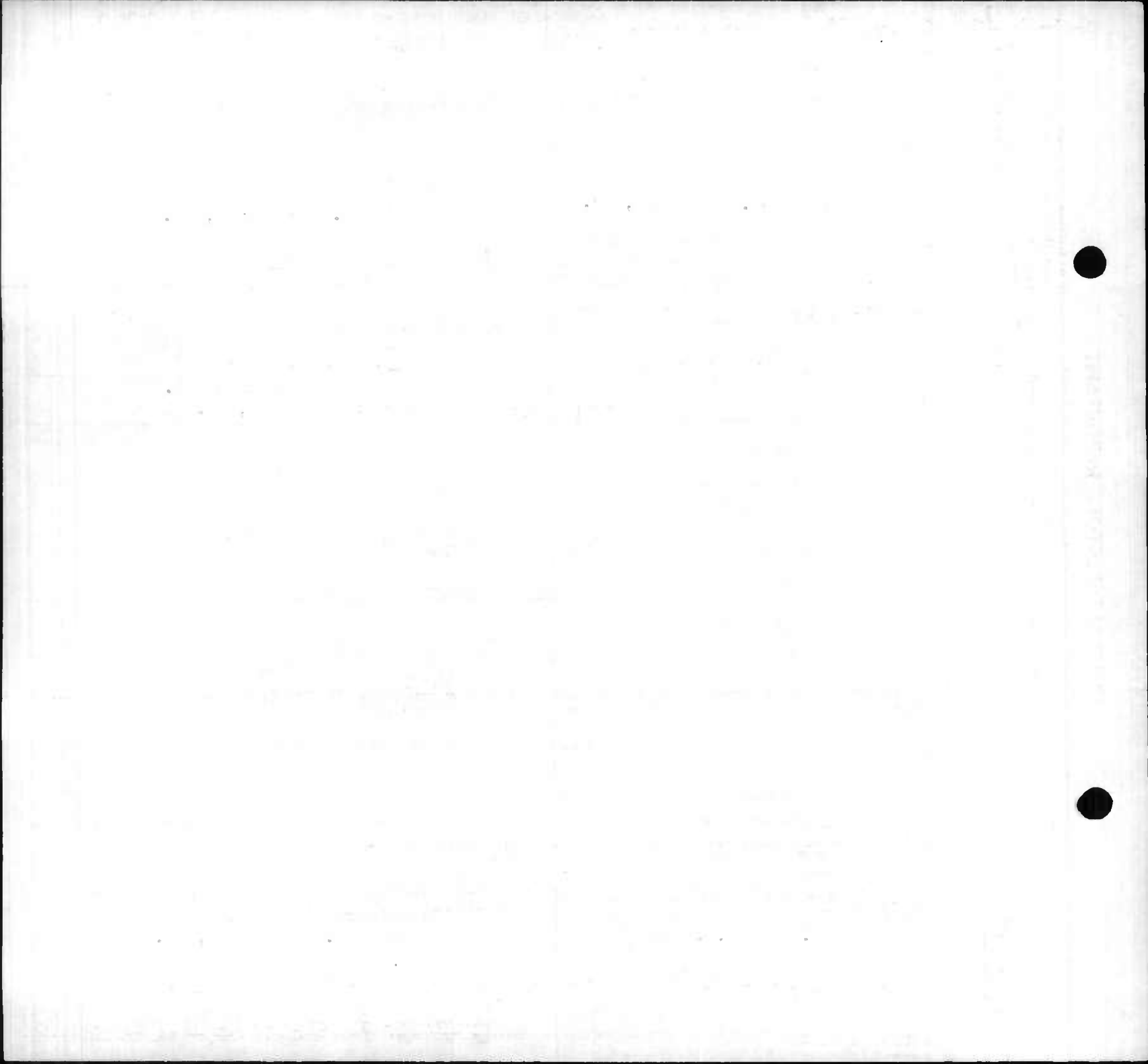
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07732
72 07732 CERTIFICATE OF DEATH				STATE OF MARYLAND-DEATH
BIRTH NO. H-243		1. NAME OF DECEASED (Type or Print) Householder E. Elizabeth		
2. DATE AND HOUR OF DEATH Aug. 13 1972 8:30 AM		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION University of Maryland Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE West. Va. B. COUNTY Paw Paw		
C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER Box 113 Paw Paw, West. Va				
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-8-22	
9. AGE (In years last birthday) 49		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) W. Va.
12. CITIZEN OF WHAT COUNTRY? American		13. FATHER'S NAME Frank L. Parker		
14. MOTHER'S MAIDEN NAME Annabelle Bowley		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.		17. INFORMANT MELVIN K. HOUSEHOLDER ADDRESS PAW PAW, 25434 W. VA.		
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				
ANTECEDENT CAUSES				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
(A) IMMEDIATE CAUSE UNKNOWN				
DUE TO, OR AS A CONSEQUENCE OF:				
(B) RADICAL SURGERY DUE TO				
DUE TO, OR AS A CONSEQUENCE OF:				
(C) RECURRENT Sq.C. CA OF Cx				19 days
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 7-25-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Recurrent Cervical Cancer		20A. AUTOPSY? (Yes or No) No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		
21F. HOW DID INJURY OCCUR?		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 7-16 19 72 to 8-13 19 72				
that (I) we lost saw the deceased alive on 8-13 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Jackson C. Huang MD		23B. DATE SIGNED 8-13-72		23C. PHYSICIAN'S NAME (Type) JACKSON C. HUANG MD
23D. ADDRESS 4612-B PEN LUCY RD Balto		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 8/15/72		24C. NAME OF CEMETERY or CREMATORY WOODROW		24D. LOCATION (City, town, or county) (State) Paw Paw, (MORGAN) W. VA.
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972		25B. NAME OF REGISTRAR Johnston		25C. FUNERAL DIRECTOR Johnston ADDRESS Berkley Springs W. Va.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07793	
BIRTH NO. 72 07793				CERTIFICATE OF DEATH	
STATE OF MARYLAND-DHME					
1. NAME OF DECEASED (Type or Print) Bertha L. Wilson			2. DATE AND HOUR OF DEATH 13 AUG 72 1 815 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 Eastern Ave. Baltimore, Md. 21224			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN DUNDALK D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 75 Kinship Rd. Baltimore, Md. 21222		
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 MAY 1898		9. AGE (In years lost birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Henry W. MEEKINS		
14. MOTHER'S MAIDEN NAME Ada I. WHITELOCK			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.		
16. SOCIAL SECURITY NO. 215-01-0113D			17. INFORMANT BCH Records: Baltimore, Md. 21224		
18. CAUSE OF DEATH 530.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Aspiration Pneumonia Esophageal Obstruction II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 1793			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/10 19 72 to 8/13 19 72 that (I) (we) last saw the deceased alive on 8/13 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Fine			23B. DATE SIGNED 8/13/72		23C. PHYSICIAN'S NAME (Type) M. Fine M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 16 AUG 72		24C. NAME of CEMETERY or CREMATORY BALTIMORE NATIONAL CEM. BALTIMORE, MD.
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972			25B. NAME OF REGISTRAR Frederick J. ...		25C. FUNERAL DIRECTOR WILKINSON FUNERAL HOME, DUNDALK, MD.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07794		REG. NO. 72 07794	
K-400				72 07794			
BIRTH NO.				STATE OF MARYLAND - DEPT.			
1. NAME OF DECEASED (Type or Print) KEIL ROLAND				2. DATE AND HOUR OF DEATH 08-13-72 102:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 5 FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MERCY HOSPITAL - BALTO - MD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD B. COUNTY 2768			
5. SEX MALE 6. RACE W - 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH BALTO 53		9. AGE (In years last birthday) 53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BREWERY WORKER				10B. KIND OF BUSINESS OR INDUSTRY Brewery		11. BIRTHPLACE (State or foreign country) BALTO	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME HENRY KEIL			
14. MOTHER'S MAIDEN NAME GERTRUDE LILLIAN LEWIS				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2			
16. SOCIAL SECURITY NO. 215 07 0712				17. INFORMANT Kathryn M. Brewer			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE INTRA CEREBRAL HEMATOMA DUE TO, OR AS A CONSEQUENCE OF: (B) RT PARIETAL ASTROCYTOMA DUE TO, OR AS A CONSEQUENCE OF: (C)				ADDRESS 2726 Marbourn Avenue Baltimore, Maryland			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 08-09-72				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INCREASED INTRACRANIAL PRESSURE		20A. AUTOPSY? (Yes or No) —	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 and that (I) (we) lost saw the deceased alive on 08-13-1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Gustavo R. Roca				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) GUSTAVO R. ROCA	
23D. ADDRESS MERCY HOSPITAL - BALTO.				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 8-16-72				24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972				25B. NAME OF REGISTRAR Andrew Johnston		25C. FUNERAL DIRECTOR McGully Funeral Home	
25D. ADDRESS 130 East Fort Avenue Balto., Md. 21230							

WEEKLY WORKER
DATE 23

DATE 23

DATE 23

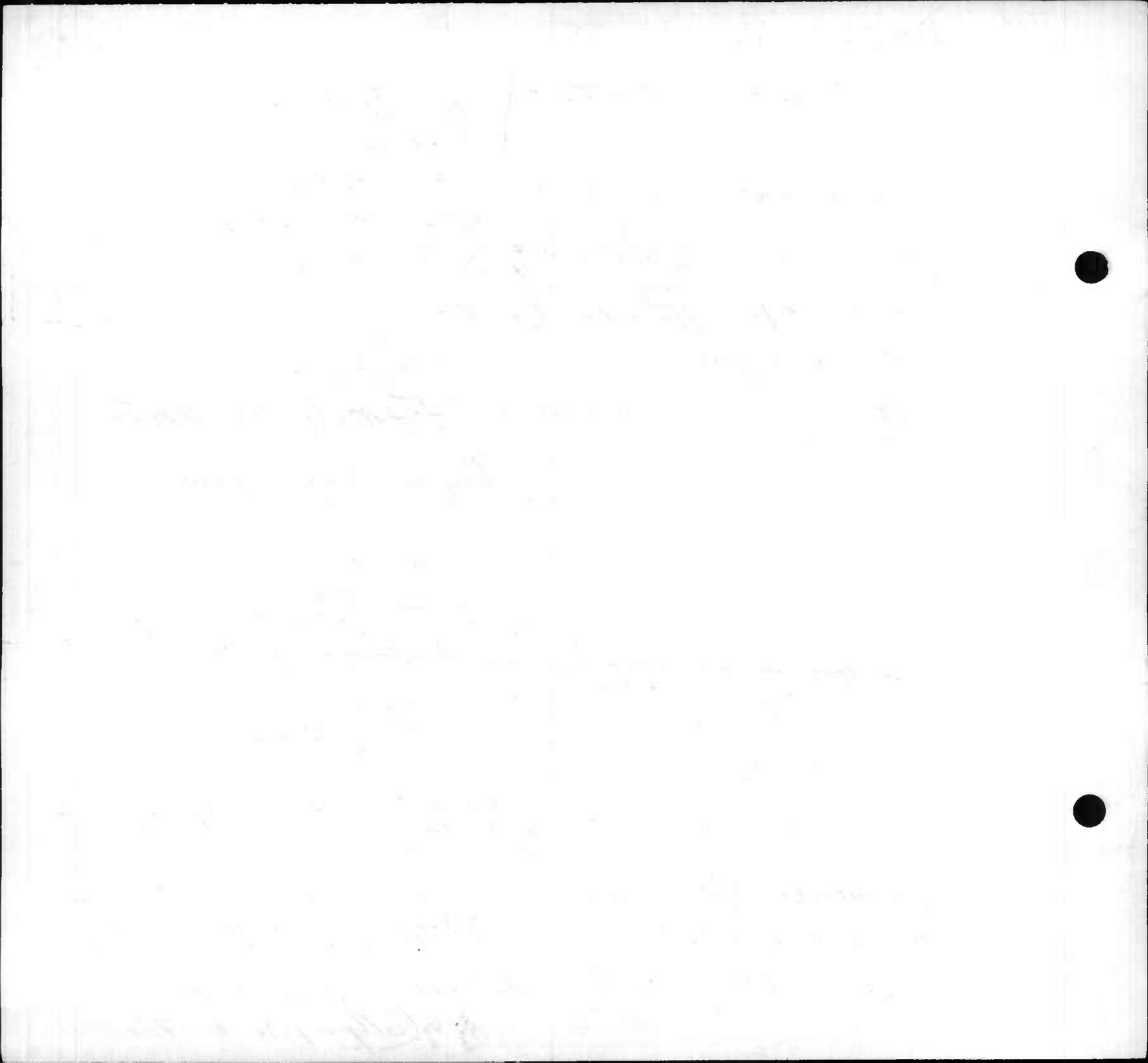
08-13

DATE 23

DATE 23

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-632		72 07795		BALTIMORE CITY HEALTH DEPARTMENT		72 07795	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) OSCAR DORTCH				2. DATE AND HOUR OF DEATH MARYLAND - DIME 8/14/72 3-25PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CHURCH HOME & HOSPITAL 35				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2201			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME & HOSPITAL 35				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 123 - E MONTGOMERY ST.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 06-26-23	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mach. Op				10B. KIND OF BUSINESS OR INDUSTRY ROUSE CO		11. BIRTHPLACE (State or foreign country) VA	
13. FATHER'S NAME WILLIE DORTCH				14. MOTHER'S MAIDEN NAME ADA WEEKS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 227-18-8450		17. INFORMANT FAMILY - SAME	
18. 450X17121 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) IMMEDIATE CAUSE PULMONARY EMBOLISM. DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CANCER @ LUNG - PNEUMONECTOMY - 1971? PARAPLEGIA - IRRADIATION MYELOPATHY? SECONDARY INVOLVEMENT?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE		20A. AUTOPSY? (Yes or No) NONE		20B. IF YES, WERE FINDINGS CONSIDERED IN CAUSING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) NO		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE			
21D. TIME OF INJURY (APPROX.) NONE		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/10/1972 to 8/14/1972 that (I) (we) last saw the deceased alive on 8/14/1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE K George Thomas				23B. DATE SIGNED 8/14/72		23C. PHYSICIAN'S NAME (Type) K GEORGE THOMAS	
23D. ADDRESS CHURCH HOME & HOSPITAL 100 N BROADWAY BALTO MD 21231				24A. BURIAL CREMATION, REMOVAL (Specify) NO			
24B. DATE 8-17-72		24C. NAME OF CEMETERY or CREMATORY GLENN HAVEN		24D. LOCATION (City, town, or county) (State) BALTIMORE			
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972		25B. NAME OF REGISTRAR Andrew Johnson		25C. FUNERAL DIRECTOR 130 E. FORT COE			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

Belle

1. NAME OF DECEASED
(Type or Print)

ELIZABETH TARQUINO

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

August 12, 1972

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 Baltimore City Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

August 12, 1972

5:50 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

2634

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

4/26/1881

10. AGE (in years, last birthday)

81

If Under 1 Yr. II Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1011 Hewitt Way 21205

11. BIRTHPLACE (State or foreign country)

W. Virginia

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

ANTHONY PARSONS

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

14B. KIND OF BUSINESS OR INDUSTRY

None

15. MOTHER'S MAIDEN NAME

CLAIR HENTHORNE

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL SECURITY NO.

216-511-6326

18. INFORMANT

ADDRESS

Lucille Lemmon 1011 Hewitt Way 21205

19. 412.4

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Marvin S. Platt, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 13, 1972

24A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

24B. DATE

8/16/72

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetery

24D. LOCATION (City, town, or county) (State)

Jefferson Co. Stubenville, Ohio

25A. DATE REC'D BY HEALTH DEPT.

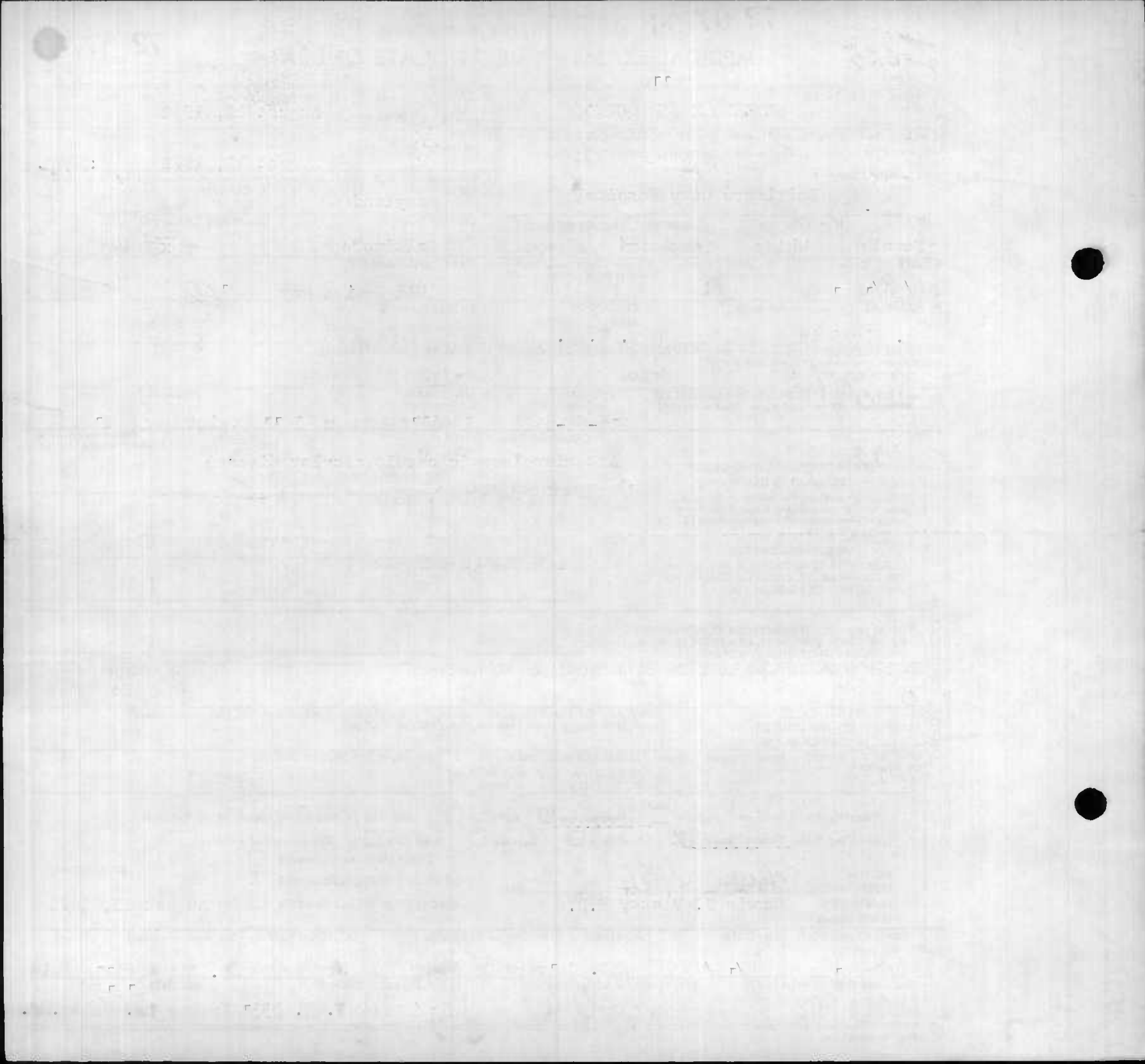
AUG 16 1972

25B. NAME OF REGISTRAR

Sidney S. Heston

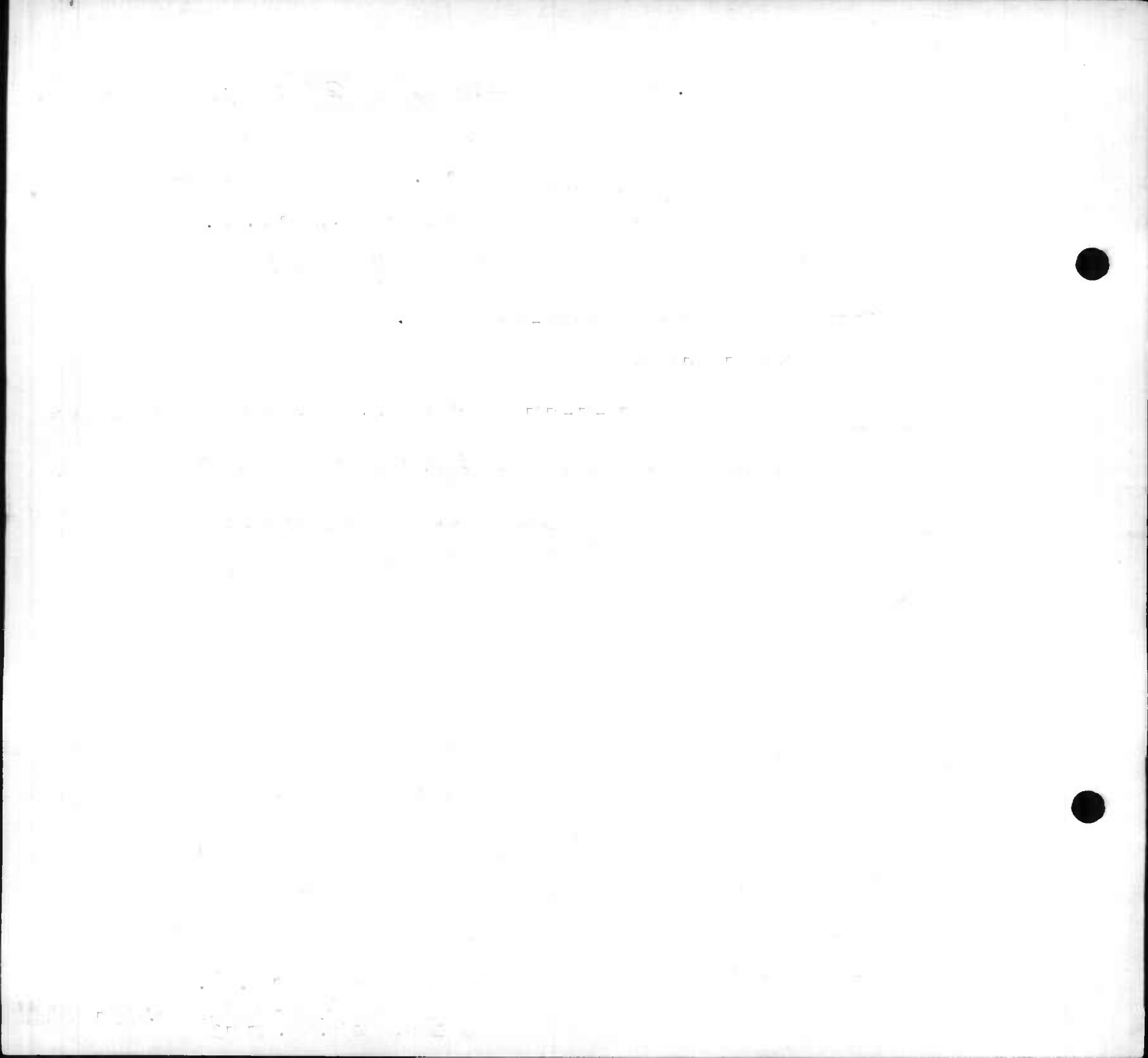
25C. FUNERAL DIRECTOR

Schimunek F. H. 3331 Brehms La. Balto. Md.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-206		72 07737		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07797		
BIRTH NO.				STATE OF MARYLAND-DEPT				
1. NAME OF DECEASED (Type or Print) <u>Teresa M. Rosso (Rosso)</u>				2. DATE AND HOUR OF DEATH <u>8/14/72</u> <u>8:43 A.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>Scnai Hospital of Baltimore</u> <u>42</u>				A. STATE <u>2244 Bank St</u> <u>21231</u>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY				
				C. CITY OR TOWN <u>Balto.</u>				
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
				E. STREET AND NUMBER <u>2244 Bank St., Balto. Md.</u> <u>105</u>				
5. SEX <u>Female</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/10/07</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>seamstress</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>House of Wrosted-Tex</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Raphael Juliano</u>				14. MOTHER'S MAIDEN NAME <u>-</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>275-07-8737</u>		17. INFORMANT <u>Vincent Rosso (husband)</u>		ADDRESS <u>same as above</u>		
18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>200.1 I</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coro. sup. arrest</u>				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Lympho. Sarcoma.</u>				
(C) DUE TO, OR AS A CONSEQUENCE OF: <u>Aplastic Anaemia.</u>								
20A. AUTOPSY? (Yes or No) <input type="checkbox"/>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>8/11/1922</u> to <u>8/11/1925</u> that (I) (we) last saw the deceased alive on <u>8/11/1922</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE <u>Rudhindra</u>				23B. DATE SIGNED <u>8/14/72</u>		23C. PHYSICIAN'S NAME (Type) <u>R. SUDHINDRA</u>		
23D. ADDRESS <u>Scnai Hosp. of Baltimore</u>				23E. FUNERAL DIRECTOR <u>Schlimmer Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/14/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Sacred Heart of Jesus Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 16 1972</u>		25B. NAME OF REGISTRAR <u>Andrew [Signature]</u>		25C. FUNERAL DIRECTOR <u>Schlimmer Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213</u>				



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07738

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LOUISE GRABOWSKI

2. DATE OF DEATH
Known ☒ Estimated ☐ Month Day Year Hour
August 11, 1972 M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospital (DOA)

3. DATE PRONOUNCED DEAD
Month Day Year Hour
August 11, 1972 9:45 A.M.5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

B. COUNTY

2605

6. SEX

Female

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Aug. 5 1929

10. AGE (In years last birthday)

43

11. Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER
(JOPLIN)
327 Joplin Avenue

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Charles Mack

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

salesclerk

14B. KIND OF BUSINESS OR INDUSTRY

Downs Lycett

15. MOTHER'S MAIDEN NAME

Florence Miller

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL SECURITY NO.

274-26-8837

18. INFORMANT

Walter Grabowski (husband)

ADDRESS

same as above
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

19.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Massive pulmonary thrombo-embolism

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Superficial thrombo-phlebitis, left popliteal region

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Marvin S. Platt, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 12, 1972

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

8/11/72

24C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION (City, town, or county) (State)

Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

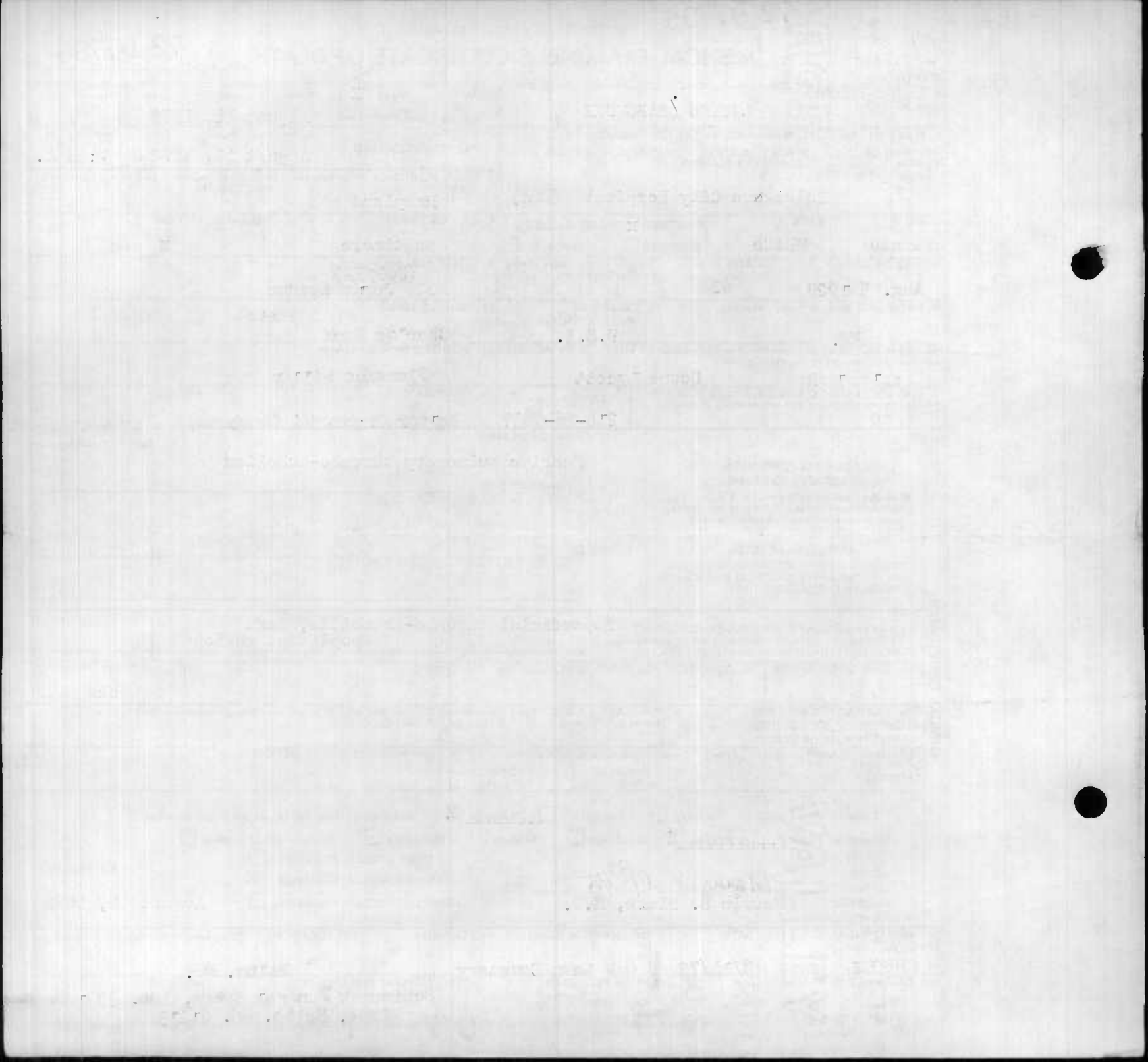
AUG 16 1972

25B. NAME OF REGISTRAR

Sidney Whorton

25C. FUNERAL DIRECTOR

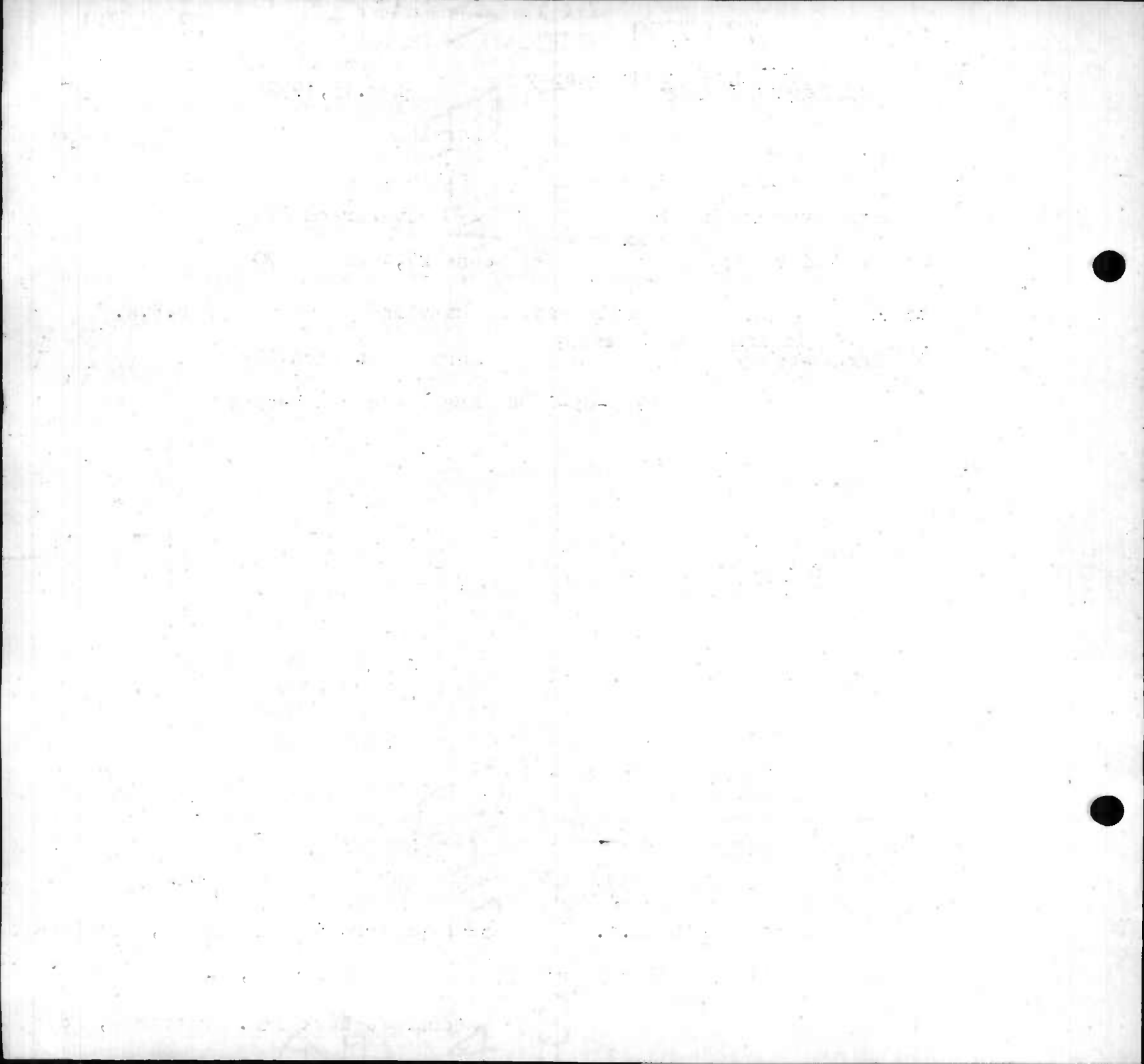
Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

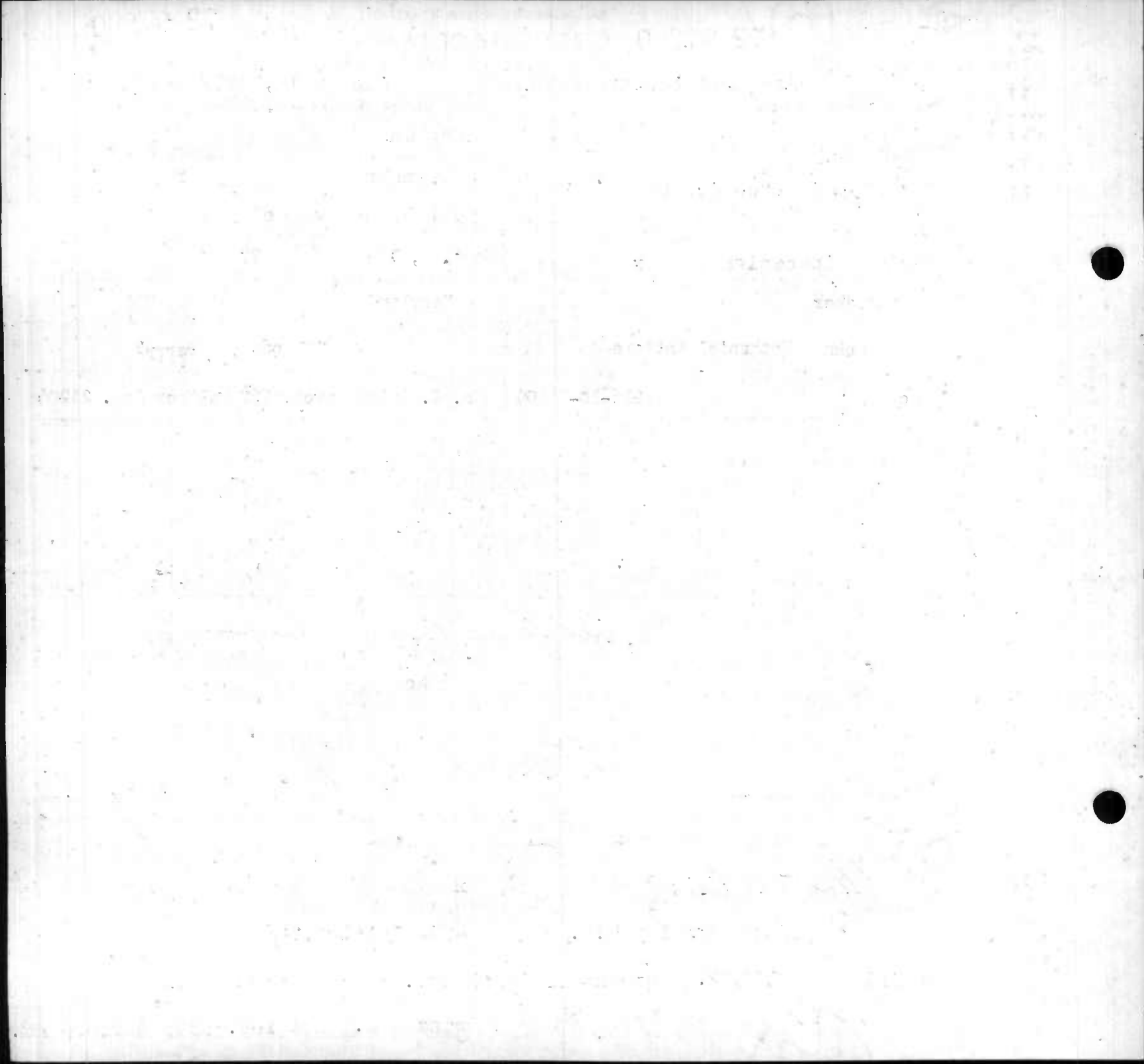
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07739
72 07739				STATE OF MARYLAND-DHMH
BIRTH NO. H-100		72 07739		M.
1. NAME OF DECEASED (Type or Print) William Emmett Heaphy		2. DATE AND HOUR OF DEATH Aug. 15, 1972		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2904 Ever Green Ave		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2706 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2904 Evergreen Ave		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1902	9. AGE (In years last birthday) 70 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Rail Road		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William Edward Heaphy		14. MOTHER'S MAIDEN NAME Mary Alice Connelly		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-05-2904		17. INFORMANT Mrs Frances E Heaphy ADDRESS Same
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cowdrey Inclusion CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Immediate APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from January 1972 to August 15 1972 , that (I) (we) last saw the deceased alive on August 14 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE James E White M.D.		23B. DATE SIGNED August 15/72		
23C. PHYSICIAN'S NAME (Type) James E White M.D.		23D. ADDRESS 5214 Harford Rd Baltimore, Maryland		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/72		24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972		25B. NAME OF REGISTRAR Leonard J Buck Inc.		25C. FUNERAL DIRECTOR ADDRESS Baltimore, Md



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

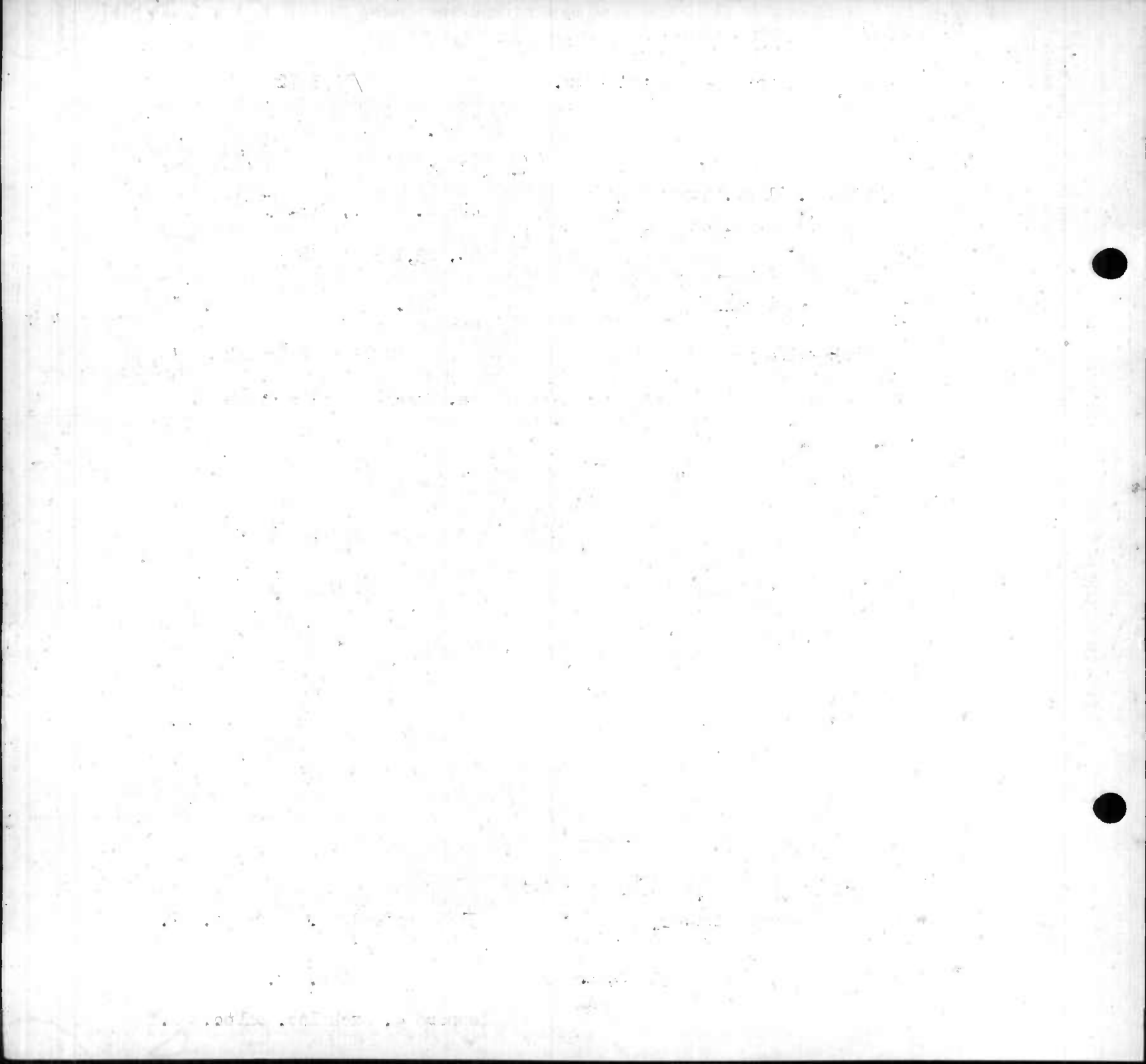
BALTIMORE CITY HEALTH DEPARTMENT		72 07800		72 07800	
P-150		72 07800		72 07800	
BIRTH NO.		72 07800		72 07800	
1. NAME OF DECEASED (Type or Print)		Margaret Loretta Pavon		2. DATE AND HOUR OF DEATH August 14, 1972 7 ⁰⁰ A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland		B. COUNTY 2631	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 5901 Grace Avenue		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 5901 Grace Avenue		5. SEX Female		6. RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 4, 1894		9. AGE (In years last birthday) 77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Nathaniel Mattare		14. MOTHER'S MAIDEN NAME Rose Perry?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-3010B		17. INFORMANT ADDRESS Mr. J. Ralph Pavon, 6222 Walther Ave. 21206	
18. 412.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Due to, or as a consequence of: Arteriosclerotic Heart Disease (B) Generalized Arteriosclerosis Due to, or as a consequence of: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic Aneurysm Hypertension Labyrinthitis		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 1/25/1965 to 8/14/1972, that (I) (we) last saw the deceased alive on 5/12/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Albert B Bradley	
23B. DATE SIGNED 8/14/72		23C. PHYSICIAN'S NAME (Type) Albert Bradley M.D.		23D. ADDRESS 4900 Belair Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/72		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972		25B. NAME OF REGISTRAR Leonard J. Ruck Inc.	
25C. FUNERAL DIRECTOR ADDRESS 5305 Harford Rd.		25D. NAME OF REGISTRAR Leonard J. Ruck Inc.		25E. FUNERAL DIRECTOR ADDRESS 5305 Harford Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07801		B-430	
CERTIFICATE OF DEATH				REG. NO. 72 07801		STATE OF MARYLAND - DEMO	
1. NAME OF DECEASED (Type or Print) Edward Joseph Balda Sr.				2. DATE AND HOUR OF DEATH 8/13/1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2025 E. 31 st. Street				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 906			
5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Feb. 23, 1898		9. AGE (In years last birthday) 74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Advertising				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ill.	
13. FATHER'S NAME Frank Balda				14. MOTHER'S MAIDEN NAME Pauline Washowiak			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Rosalind Balda same	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MI (B) Arteriosclerosis 4 yrs (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb 6/12 19 22 to 8/13 19 72 , that (I) (we) last saw the deceased alive on 6/12 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Conrad Richter				23B. DATE SIGNED 8/14/72			
23C. PHYSICIAN'S NAME (Type) Conrad Richter				23D. ADDRESS 3128 Harford Rd. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/72		24C. NAME of CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972		25B. NAME OF REGISTRAR Bridget M. ...		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.		25D. ADDRESS	



CERTIFICATE OF DEATH

REG. NO.

72 07802

STATE OF MARYLAND-DEMH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Shahan, Paris Mae

2. DATE AND HOUR OF DEATH

8/14/72

10:15 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31

Balt. City Hosp
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

6123 Fortview Way 21224

5. SEX

6. RACE

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

6/19/21

9. AGE (In years
last birthday)

51

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Harry C. Wiedefield

14. MOTHER'S MAIDEN NAME

Elsie (Unknown)

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

217-12-8598

17. INFORMANT

4940 Eastern Avenue

Baltimore, Maryland 21224

BCH: RECORDS

18.

157.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Ca Pancreas

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 8-12 1972 to 8-14 1972,
that (I) (we) last saw the deceased alive on 8-14 1972 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. Anderson

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

8-14-72

23C. PHYSICIAN'S
NAME (Type)

J. Anderson, M.D.

DEGREE

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Avenue Baltimore, Maryland 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/18/72

24C. NAME of CEMETERY or CREMATORY

Oaklawn Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 16 1972

25B. NAME OF REGISTRAR

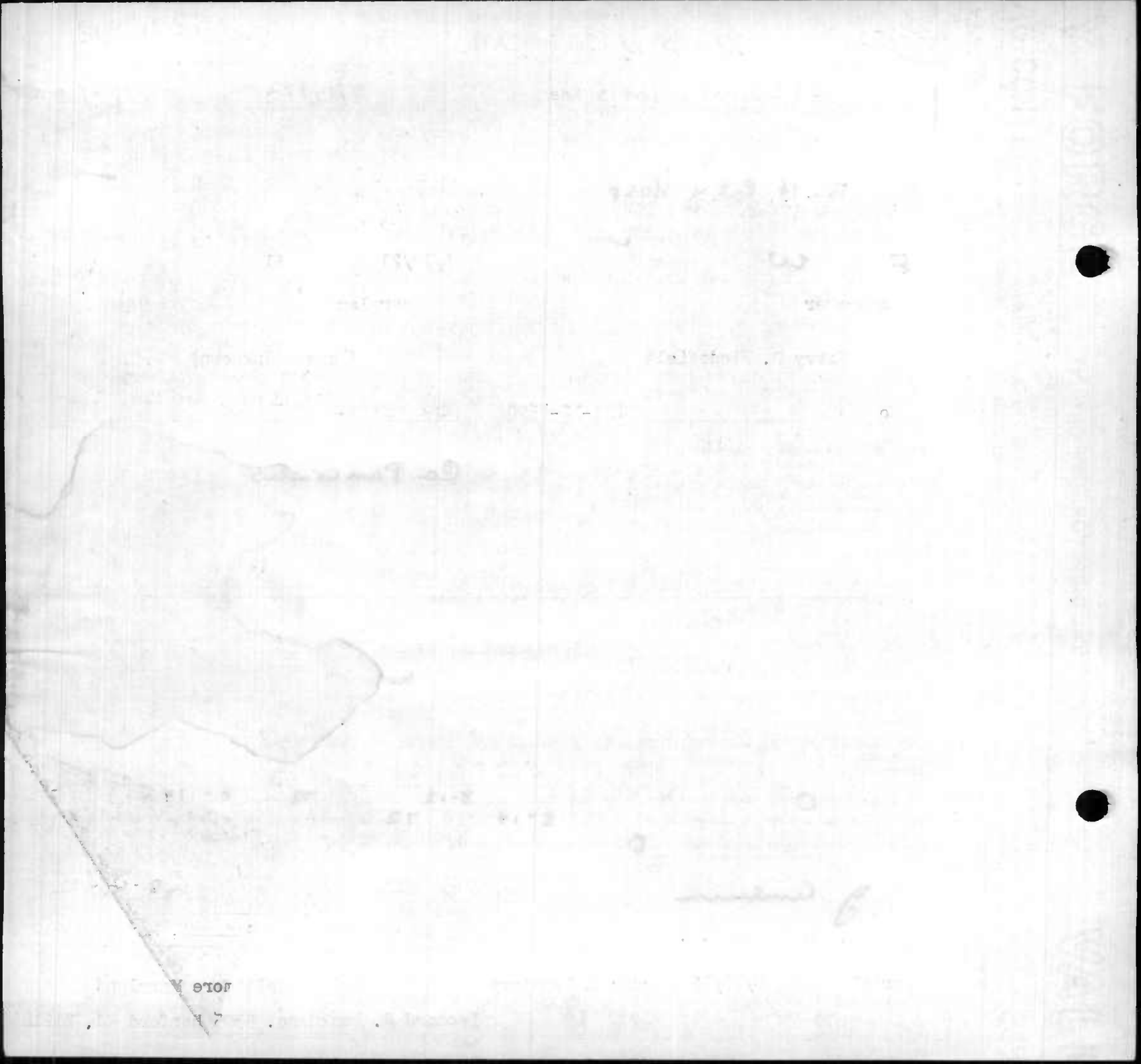
Sidney Johnson

25C. FUNERAL DIRECTOR

Leonard J. Buck Inc. 5305 Harford Rd. 21214

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

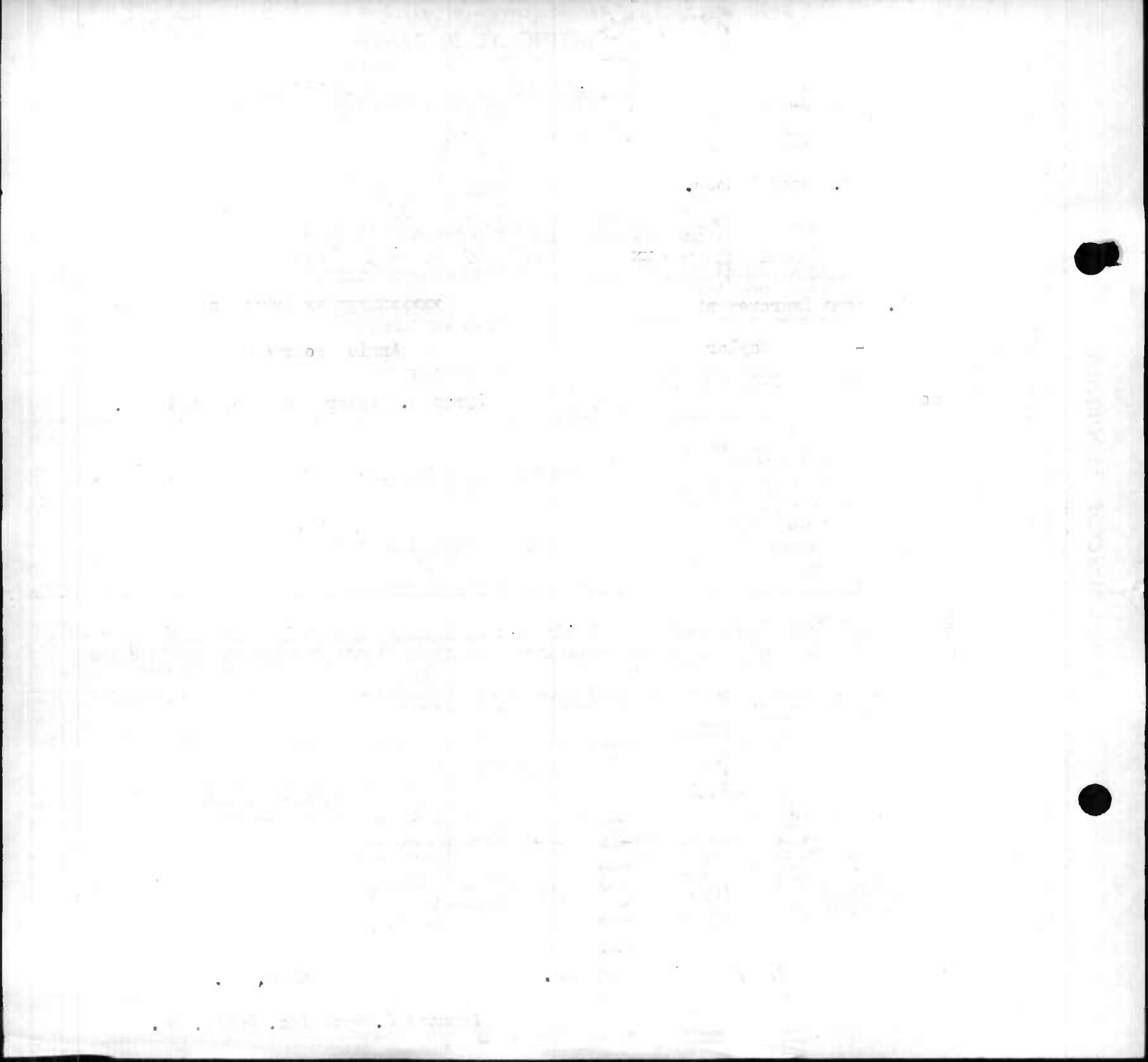
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07803
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Henry F. Durken		2. DATE AND HOUR OF DEATH 8/13/72 11:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED OEO FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 2643		
5. SEX M.		6. RACE W.		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/30/1913		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor- Balto. City Sanitation		11. BIRTHPLACE (State or foreign country) Va.		
13. FATHER'S NAME Luke Durken		14. MOTHER'S MAIDEN NAME Bessie Branson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-05-5236		
17. INFORMANT Mrs. Ellen Durken same		ADDRESS		
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div> <div style="margin-top: 10px;"> (A) IMMEDIATE CAUSE Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF: </div> <div style="margin-top: 10px;"> (B) A.S.H.D. DUE TO, OR AS A CONSEQUENCE OF: </div> <div style="margin-top: 10px;"> (C) </div>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Ceilar E. Parra		23B. DATE SIGNED Aug. 14, 1972		
23C. PHYSICIAN'S NAME (Type) Ceilar E. Parra MD		23D. ADDRESS 7122 Harford Rd. Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/72		
24C. NAME OF CEMETERY or CREMATORY Moreland Mem.		24D. LOCATION (City, town, or county) (State) Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972		25B. NAME OF REGISTRAR A. J. Ruck		
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.		ADDRESS		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07804
T-460 72 07804				STATE OF MARYLAND-DEATH
BIRTH NO. T-460		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Taylor, Mr. George W.		2. DATE AND HOUR OF DEATH 8-11-72 5:03 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 48 Md. General Hosp.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 0		
FULL NAME OF HOSPITAL OR INSTITUTION 48 Md. General Hosp.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M		6. RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 12-15-96		9. AGE (In years last birthday) 75		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Home Improvement		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) California
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Taylor		
14. MOTHER'S MAIDEN NAME Annie Crosswood		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 219-01-4958		17. INFORMANT ADDRESS Myron E. Taylor 1621 Glen Eagle Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 599.0 I		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septicemia		
		(B) DUE TO, OR AS A CONSEQUENCE OF: Urinary Tract Infection		
		(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Arteriosclerotic Cerebrovascular Disease		years		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1970 to 8-11-1972 that (I) (we) last saw the deceased alive on 8-11-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE L. Kemper Owens M.D.		23B. DATE SIGNED 8-11-72		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 1020 St. Paul St., Balto., Md. 21202		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/14/72		24C. NAME OF CEMETERY or CREMATORY Moreland Mem.
24D. LOCATION Balto. Md.				
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972		25B. NAME OF REGISTRAR Arden J. Gordon		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07805

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Norbert J. Gloster		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 8 11 72 10:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home & Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 11 72 10:45 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY BALTO	
9. DATE OF BIRTH Nov. 17, 1914		10. AGE (In years lost birthday) X61 58	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter		15. MOTHER'S MAIDEN NAME Mary C. Dietrich	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		17. SOCIAL SECURITY NO. 578-09-5788	
18. INFORMANT Mrs. Marie F. Smith		19. CAUSE OF DEATH 011.3 I	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Active pulmonary tuberculosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Cirrhosis of liver			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W P Mulloy EXAMINER'S NAME (Type) William P. Mulloy, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/15/72	
24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972		25B. NAME OF REGISTRAR Sidney Johnston	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto., Md.		ADDRESS	

II

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07806	
T-500 72 07806				STATE OF MARYLAND - DHMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Frank Thim		August 12, 1972 5:32 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			A. STATE B. COUNTY Maryland Baltimore		
			C. CITY OR TOWN Essex		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER 105 Riverside Drive 21221		
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-7-91	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Wood Worker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Sebastian Thim			
14. MOTHER'S MAIDEN NAME Katharina Rudel		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service Yes WW 1			
16. SOCIAL SECURITY NO. 212-16-4518A		17. INFORMANT 4940 Eastern Avenue Baltimore, Maryland 21224 BCH: RECORDS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cardiogenic shock (B) DUE TO, OR AS A CONSEQUENCE OF: myocardial infarction (C) anterosclerotic cardiovascular disease unknown		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 h			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). malignant melanoma of jaw					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/12 1972 to 8/12 1972 that (I) (we) last saw the deceased alive on 8/12 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hubert G. Markley M.D.				23B. DATE SIGNED 8/12/72	
23C. PHYSICIAN'S NAME (Type) Hubert G. Markley, M.D.				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-16-72		24C. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer Cem.	
24D. LOCATION (City, town, or county) Balto. Md.		24E. NAME OF REGISTRAR Leonard J Ruck Inc.		24F. ADDRESS Balto. Md. 21214	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972		25B. NAME OF REGISTRAR Leonard J Ruck Inc.		25C. FUNERAL DIRECTOR Leonard J Ruck Inc.	

Confidential check

Important information

Attention: Cash on hand

Subject: Volume 2

NO

8/15

8/15

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8/15

Handwritten N.O.

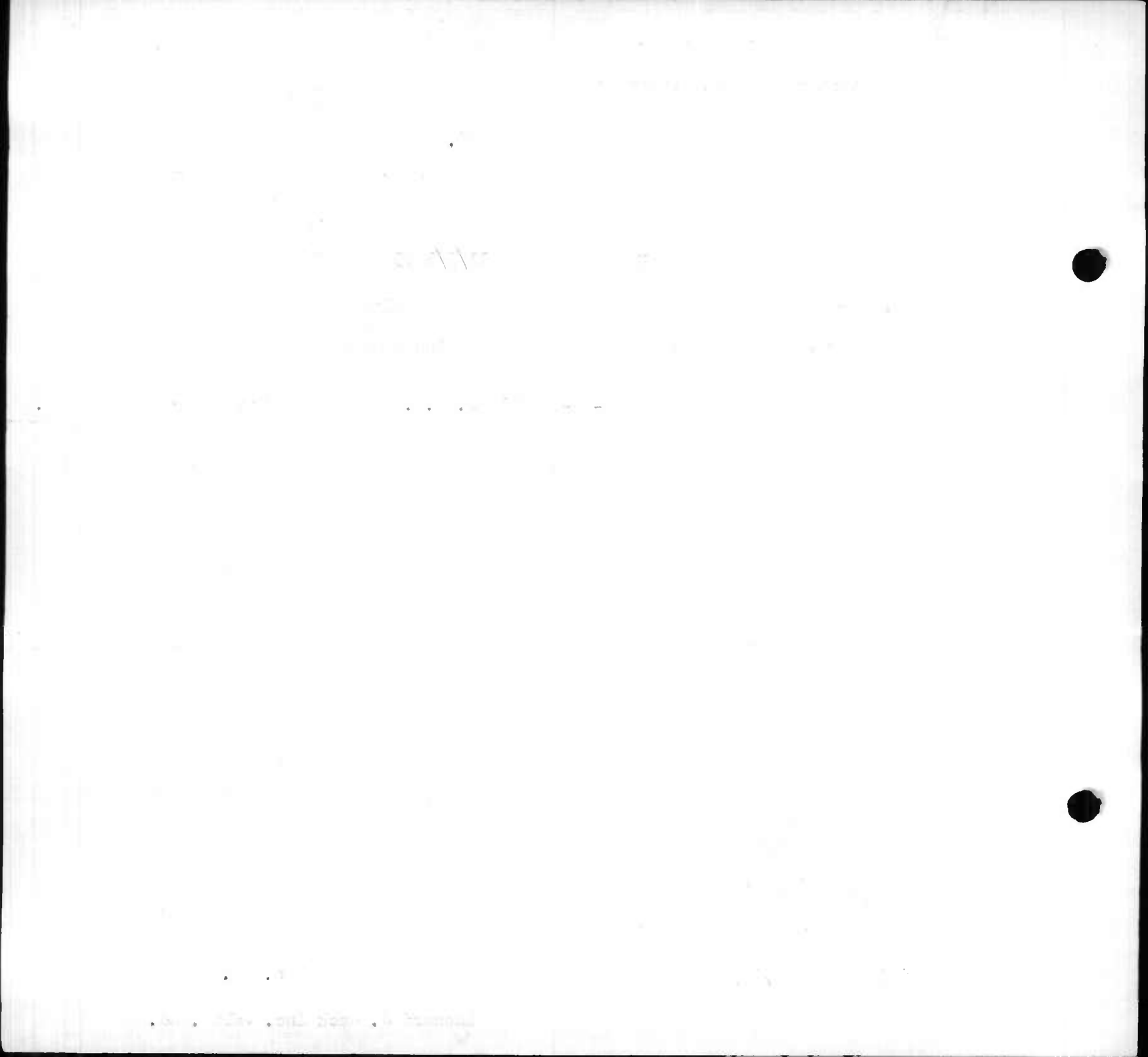
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8/15

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07807	
72 07807				D-200	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>May Duge</u>		2. DATE AND HOUR OF DEATH <u>8/13/72</u> <u>12:20 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital of Baltimore</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2730</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>3307 Shelburne Road</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/9/1893</u>		9. AGE (In years last birthday) <u>78</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>	
13. FATHER'S NAME <u>Thomas Hankinson</u>			14. MOTHER'S MAIDEN NAME <u>Annie Waters</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-48-7037J</u>		17. INFORMANT ADDRESS <u>Mr. P.S. Pantzer 3605 Forest Grove Ave.</u>	
18. <u>41213 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary artery aneurysm</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 Months</u>
			(B) <u>Cerebral Vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) <u>Arteriosclerotic heart disease</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/1</u> 19 <u>72</u> to <u>8/12</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/12</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. Sudhindra</u>			23B. DATE SIGNED <u>8/13/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>R. SUDHINDRA</u>			23D. ADDRESS <u>Sinai Hosp.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/16/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Parkwood</u>	
				24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE RECD. BY HEALTH DEPT. <u>AUG 16 1972</u>		25B. NAME OF REGISTRAR <u>Adrian K. Horton</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck Inc. Balto. Md.</u>	



72 07808

CERTIFICATE OF DEATH

REG. NO.

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MADDOX, WILLIE

2. DATE AND HOUR OF DEATH

8/13/72 8:45 PM

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Baltimore City Hospital
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

522 W. Lanvale Street

5. SEX

Male

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

4/23/00

9. AGE (In years
last birthday)

72

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

??

14. MOTHER'S MAIDEN NAME

??

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

218-18-8451

17. INFORMANT

4940 Eastern Avenue ADDRESS

BCH RECORDS: Baltimore, Maryland 21224

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.Acute Pulmonary distress
(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia, Carcinoma of Prostate-
(B) To with Hepatitis, Paraplegia. 3 Years

DUE TO, OR AS A CONSEQUENCE OF:

(C) Urinary tract infect. Long th. 15 years
2 monthAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 weeks

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 26 1972 to Aug. 13 1972
that (I) (we) last saw the deceased alive on Aug 13 1972 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Hiroshi Mitsuoto

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

August 13, 1972

23C. PHYSICIAN'S
NAME (Type)

HIROSHI MITSUMOTO, M.D.

23D. ADDRESS

Baltimore City Hospitals

4940 E. Ave. Balto.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/17/71

24C. NAME OF CEMETERY or CREMATORY

MT Calvary Cemetery

24D. LOCATION

A A County

(City, town, or county)

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

AUG 16 1972

25B. NAME OF REGISTRAR

Andrew H. Horton

25C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

11-380

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/6B

1972

AUGUST 12, 1972

NEW YORK, NEW YORK

NEW YORK

NEW YORK

ST. LOUIS, MISSOURI

NEW YORK, NEW YORK

X

HALE, CAROLAN

ST. LOUIS, MISSOURI

NEW YORK, NEW YORK

ST. LOUIS, MISSOURI

NEW YORK, NEW YORK

ST. LOUIS, MISSOURI

NEW YORK, NEW YORK

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

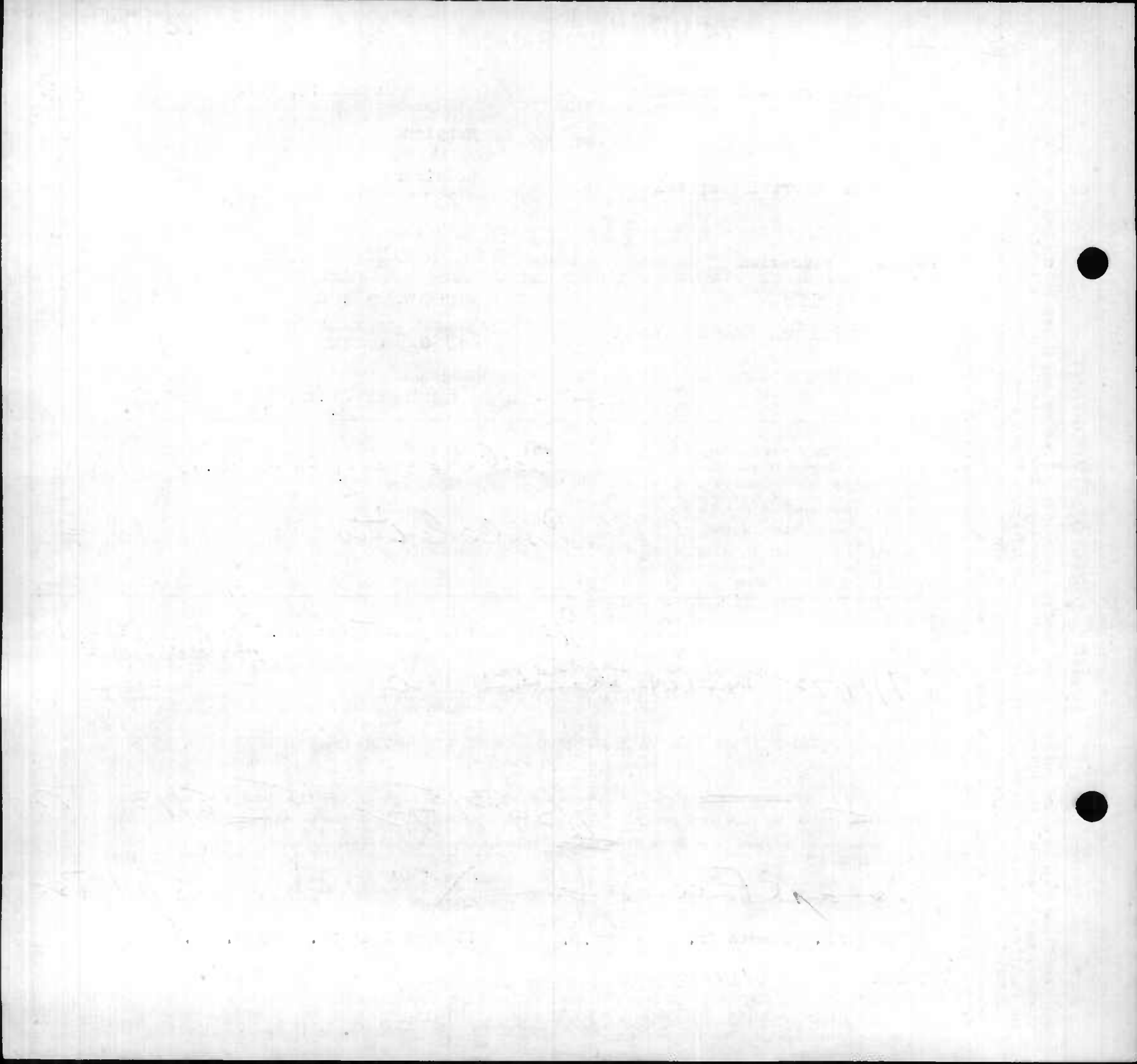
ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07810		REG. NO. 72 07810	
CERTIFICATE OF DEATH							
STATE OF MARYLAND-DHMH							
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Kazimiera Julia Gzowski				August 13, 1972 6 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital				A. STATE Maryland			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY			
44				C. CITY OR TOWN Baltimore			
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 3311 Guilford Ave.							
5. SEX female	6. RACE caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/18/1910	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Warsaw, Poland		12. CITIZEN OF WHAT COUNTRY? Poland
13. FATHER'S NAME Wojciech Stempkowski			14. MOTHER'S MAIDEN NAME Zofja Berger				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 219-30-6109		17. INFORMANT husband Stanislaw Gzowski		
			ADDRESS 3311 Guilford Ave.				
18. 457.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Pneumonia DUE TO, OR AS A CONSEQUENCE OF:			1 mo	
(C) _____							
II			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Rheumatic heart disease			10 yr.	
19A. DATE OF OPERATION 7/19/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED member of operation		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from 3/5 1965 to 8/13 1972 that (I) (we) lost saw the deceased alive on 7/29 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE Norman R. Freeman, Jr.				23B. DATE SIGNED 8/14/72			
23C. PHYSICIAN'S NAME (Type) Norman R. Freeman, Jr.				23D. ADDRESS 111 West 29th St. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 8/17/72		24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) Balto, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972		25B. NAME OF REGISTRAR Adrian K. Kowalski		25C. FUNERAL DIRECTOR Charles D. Sadowski		ADDRESS 1937 Gough St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07811	
W-240 72 07811				STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
WEGEL, GEORGE			AUGUST 13, 1972 6:50 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 4-0 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229			A. STATE MARYLAND ANNE ARUNDEL 21090 C. CITY OR TOWN LINTHICUM D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XXX E. STREET AND NUMBER 508 MEDORA ROAD 5200		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	CAUCASIAN		02/09/90	82	BARBER
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			AUSTRIA		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
HENRY WEGEL			Anna Feiler		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
NO			216-32-2438		BALTO MD 21229
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			19. CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Respiratory arrest		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Chronic obstructive lung disease		
II			(B) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(C)		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
					NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from JULY 21 19 72 to AUGUST 13 19 72, that (X) (we) last saw the deceased alive on AUGUST 13 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
E. Barner MD			8/13/72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
EDUARDO G. ROMERO MD			ST. AGNES HOSPITAL WILKENS & CATON AVES.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
Burial		8/16/72	Holy Cross		Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 16 1972		Sidney J. Kuntz		Edw. S. MacNabb Sons, Inc.	
				301 Frederick Rd. Catonsville, Md.	

6:30 A.

AUGUST 12, 1972

WHEEL, GEORGE

MARYLAND, FINE ARREST, 1969

XX

BALTIMORE, MARYLAND 21522 EEO MEDICAL ROAD

02/00/90 XX

U.S.A. 11/28/71 248028

and Teller

HEATHY WHEEL

516-22-2222 ST ASHES, RECORDS CATON, 2 WILKINS

NO

AUGUST 12 1972 JULY 21 1972 AUGUST 12 1972

ST. AGNES HOSPITAL
1111 KENYON & CATON AVES.

Burial 8/26/72 Holy Cross Baltimore, Maryland

301 Frederick St. Catonsville, Md.
Rev. S. Macpherson, Inc.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FRANK ALEXANDER		Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour		8 14 1972 9:28 a		A. STATE B. COUNTY	
So. Balto. Gen. Hosp. (DOA)		Md.		2552					
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
male		negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
5/2/20		52		South Carolina		U.S.		Borie Alexander	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME					
Chauffeur		Trucking		Emma Frier					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS			
Yes		213-16-3685		Elizabeth Jarvis		411 Roundview Rd.			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Hypertensive cardiovascular disease							
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO, OR AS A CONSEQUENCE OF:							
		(B)							
		DUE TO, OR AS A CONSEQUENCE OF:							
		(C)							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)					
				no					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
23.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from:							
		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED					
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER							
Ronald N. Kornblum, M.D.		ASSOCIATE MEDICAL EXAMINER							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		8/19/72		Maryland Nat'l Mem.Pk.		Laurel, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
AUG 16 1972		Sidney W. Norton		Charles A. Rice		1300 Eutaw Place			

CHAS. H. HARRIS

50, 100, 200, 500, 1000

1000

1000

1000

Respectfully, your obedient servant,

[Handwritten signature]

Charles H. Harris, Esq., 1000

FUNERAL DIRECTOR: IMPORTANT

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B-635		72 07813		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07813	
BIRTH NO.				STATE OF MARYLAND-DEME			
1. NAME OF DECEASED (Type or Print) SAM BIRDEN or (BURDEN)				2. DATE AND HOUR OF DEATH 8-14-72 1:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION San M. Baltimore Gen Hospital 4333 3001 Hanover St Baltimore, Maryland				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3520 Round Rd.			
5. SEX M	6. RACE B	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-5-18	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 247-20-6205		17. INFORMANT ADDRESS Jennie Burden 3520 Round Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Nephrotic Syndrome DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II Hypoglycemic Attacks (Seizures)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 7-28-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-28-72 19 72 to 8-14 19 72 that (I) (we) last saw the deceased alive on 8-14 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE B O'Keefe MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> notem		23B. DATE SIGNED 8-14-72	
23C. PHYSICIAN'S NAME (Type) O'Keefe MD				23D. ADDRESS THIS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/20/72		24C. NAME OF CEMETERY OR CREMATORY Church Cemetery		24D. LOCATION (City, town, or county) (State) Int. Corner South Carolina	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972		25B. NAME OF REGISTRAR Lidney Horton		25C. FUNERAL DIRECTOR ADDRESS Charles A. Rice 1300 Eutaw Place			

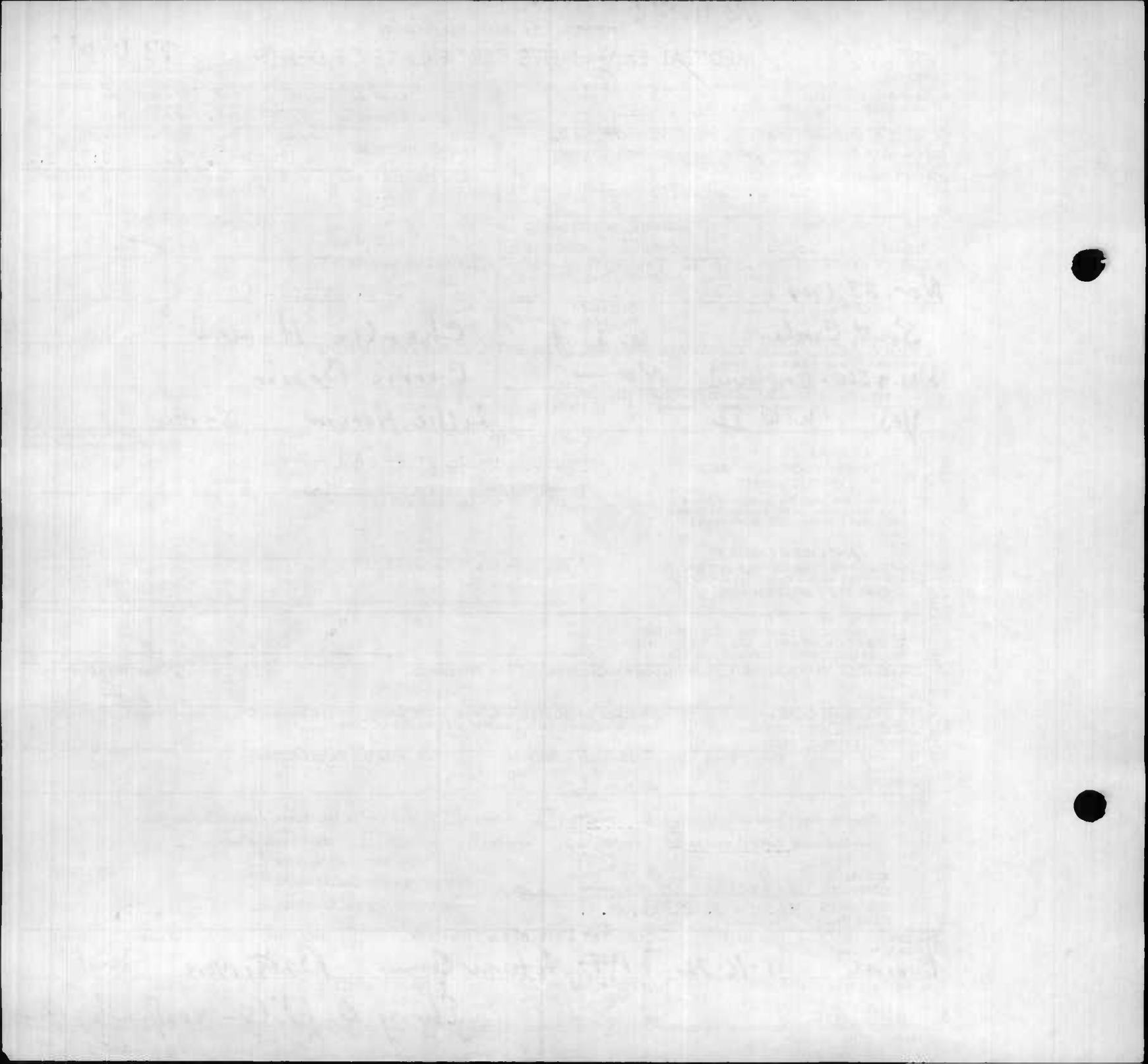
PC

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) THOMAS HARVIN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month August Day 11 Year 1972 Estimated <input type="checkbox"/>		3. DATE PRONOUNCED DEAD Month August Day 11 Year 1972 Hour 8:55 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 610 N. Carrollton Avenue		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1601		6. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH Nov. 22, 1919	
10. AGE (In years last birthday) 53		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charlie Harvin		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mas. & Elec. Employee		15. MOTHER'S MAIDEN NAME Carrie Bosier	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) Yes WW II		17. SOCIAL SECURITY NO.		18. INFORMANT Lillie Harvin ADDRESS Same	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Marvin S. Platt, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED August 12, 1972 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-16-72		24C. NAME of CEMETERY or CREMATORY MT. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972		25B. NAME OF REGISTRAR Aldrey Johnson	
25C. FUNERAL DIRECTOR Elroy G. Wilson		25D. ADDRESS 1000 Brantley Ave. Balto. Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-500		72 07815		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07815	
BIRTH NO.				STATE OF MARYLAND-DMHM			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
BENJAMIN FINE				AUGUST 13, 1972		8 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
3605 LABYRINTH ROAD, APT. 2 C		00		MARYLAND		2720	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				3605 LABYRINTH ROAD, APT. 2 C			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	MARCH 5, 1890	82	PROPRIETOR	LITHUANIA	USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOSEPH FINE				REBECCA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				218-32-0342		MRS. MOLLYE FINE, 3605 LABYRINTH RD., APT. 2C	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Metastatic Carcinoma 76 yrs			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Carcinoma of Bladder 76 yrs			
				(C) Prostatic Hypertrophy 76 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 4/3 1957 to 8/13 1972, that (I) (we) lost saw the deceased alive on 8/12 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Samuel Morrison				8/14/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
SAMUEL MORRISON				11 E. CHASE STREET			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		8/14/72		CHIZUKK AMUNO (ARLINGTON)		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 16 1972		Sidney H. Hinton		SOL LEVINSON & BROS.		6010 REISTERSTOWN ROAD	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-252		72 07816		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07816		STATE OF MARYLAND - DEMI	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) LESLEY XXXXXXXX ROSENSTRAUCH				2. DATE AND HOUR OF DEATH 8/12/72 6 50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE FLORIDA B. COUNTY V09			
FULL NAME OF HOSPITAL OR INSTITUTION USPHS HOSPITAL 3100 WYMAN PKDR						C. CITY OR TOWN MIAMI BEACH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						D. INSIDE CITY LIMITS?			
E. STREET AND NUMBER 1025 47th Ct									
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 3/27/49		9. AGE (In years last birthday) 23		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) MIAMI BEACH, FLORIDA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME HENRY REINHARD						14. MOTHER'S MAIDEN NAME CAROLYN CHERRY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO						16. SOCIAL SECURITY NO.		17. INFORMANT 710 SW 12th Ave Golden Jural Home - Miami Florida	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYELOCYTIC LEUKEMIA						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PULMONARY EDEMA, GIBBLEE									
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). PULMONARY EDEMA, GIBBLEE						DAYS			
19A. DATE OF OPERATION 21				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 5/10 1972 to 8/12 1972. that (I) (we) last saw the deceased alive on 8/12 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE V. L. Bauer, M.D.						23B. DATE SIGNED 8/12/72			
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS			
24A. BURIAL, CREMATION, REMOVAL (Specify)						24B. DATE 8/12/72		24C. NAME OF CEMETERY or CREMATORY M. NEBO	
24D. LOCATION (City, town, or county) (State) Miami Florida									
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972				25B. NAME OF REGISTRAR D. J. Johnson		25C. FUNERAL DIRECTOR 6010 Gusterstown Rd.			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LORIE ANDERSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 12, 1972 Hour 1:55 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour August 12, 1972 1:55 A. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Brunswick	
9. DATE OF BIRTH 11-21-61		10. AGE (In years last birthday) 10	
11. BIRTHPLACE (State or foreign country) Savannah Georgia		12. CITIZEN OF U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME Merle E. Anderson		15. MOTHER'S MAIDEN NAME Georgia Jean Sharitz	
18. INFORMANT Georgia Jean Sharitz		ADDRESS Brunswick	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Multiple injuries		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22D. TIME OF INJURY (APPROX.) Month (Day) (Year) (Hour) 8-11-72 11:00 P.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Rt. 340 W. of Sandy Hook Area		22F. HOW DID INJURY OCCUR? Passenger in car that failed to make a turn in road and ended up in field	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Marvin S. Platt, M.D.		DATE SIGNED August 12, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 8/15/72	
24C. NAME of CEMETERY or CREMATORY St. Mark's Cemetery		24D. LOCATION (City, town, or county) (State) Petersville Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 16 1972		25B. NAME OF REGISTRAR Adrian J. Horton	
25C. FUNERAL DIRECTOR Feete Funeral Home		ADDRESS Brunswick, Maryland	

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SAINT JOHN'S COLLEGE

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

M-600		72 07818		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07818	
BIRTH NO.				STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print) EDWIN C. MOORE				2. DATE AND HOUR OF DEATH 7/1/72 5:59 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) USPHS HOSP 3100 WYMAN PARK DRIVE BALTIMORE, Md				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER MARYLANDER APTS ST PAUL + UNIVERSITY, BALT. Md			
5. SEX M	6. RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/13/06	9. AGE (In years lost birthday) 65	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ARMY CAPTAIN		
11. BIRTHPLACE (State or foreign country) MICHIGAN				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHARLES E. MOORE				14. MOTHER'S MAIDEN NAME ADAH S. LAMBE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 1925 to 1956				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS OLD CHART AND PATIENT	
18. 723.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: INTRAMEDULLARY NAILING OF RIGHT FEMORAL SHAFT ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) INTRAMEDULLARY NAILING OF RIGHT FEMORAL SHAFT UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 5 DAYS			
19A. DATE OF OPERATION 6/26/72				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED STRESS FRACTURE FEMUR		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> NONE				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) NONE				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? NONE	
22. I certify that (I) (this hospital) attended the deceased from JUNE 16 1972 to JULY 1 1972 , that (I) (we) last saw the deceased alive on JULY 1 1972 and that in (my) (our) opinion death occurred on the date JULY 1 1972 and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert Stone Baxt MD				23B. DATE SIGNED 7/1/72		23C. PHYSICIAN'S NAME (Type) ROBERT STONE BAXT MD	
24A. BURIAL CREMATION, REMOVAL (Specify) 1-5-72				24B. DATE		24C. NAME OF CEMETERY or CREMATORY BALTIMORE BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972				25B. NAME OF REGISTRAR Lidney		25C. FUNERAL DIRECTOR ADDRESS UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07819		BALTIMORE CITY HEALTH DEPARTMENT		72 07819	
D-250 72 07819		72 07819		72 07819	
BIRTH NO. 72-07476		CERTIFICATE OF DEATH		REG. NO. STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <u>DIXON, BABY GIRL</u>		2. DATE AND HOUR OF DEATH <u>5-31-72</u> <u>5:30</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2798</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>LUTHERAN HOSPITAL OF MARYLAND</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>4829 Wilern Ave</u>			
5. SEX <u>FE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-23-72</u>	9. AGE (In years lost birthday) <u>7 days</u>	10. Under 1 Yr. Months Days <u>7</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>LAYADIA DIXON</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>72 07819</u> I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary hemorrhage</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinite medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/24</u> 19 <u>72</u> to <u>5/30</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>5/30</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. Eupenio M.D.</u>		23B. DATE SIGNED <u>5/30/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>J. EUPENIO M.D.</u>		23D. ADDRESS <u>Lutheran Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>7-3-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>ANATOMY BOARD OF MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 17 1972</u>		25B. NAME OF REGISTRAR <u>L. J. Curran</u>		25C. FUNERAL DIRECTOR ADDRESS <u>UNIVERSITY MEDICAL SCHOOL</u>	

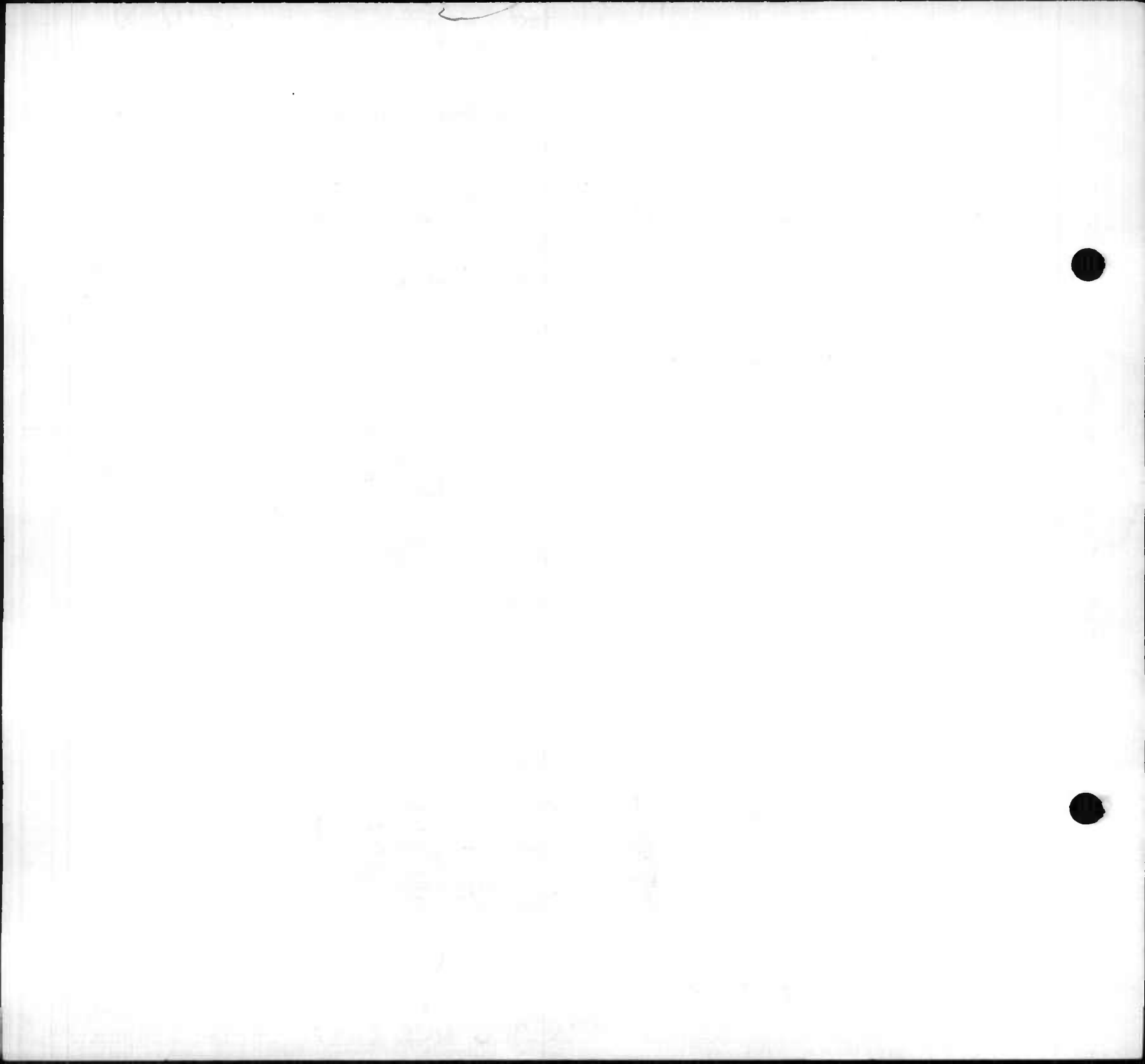


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07820	
B-246 72-08386 72 07820				CERTIFICATE OF DEATH	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) BABY GIRL BASIL				2. DATE AND HOUR OF DEATH 6.12.72 6 AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY AA	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE 2 BELVEDERE AT GREENSPRING BALTIMORE 21215.				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER SINAI HOSP 1019 Charter Road 21061					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6.10.72	9. AGE (In years lost birthday) 36
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BABY				10B. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD J. BASIL				14. MOTHER'S MAIDEN NAME CHERYL	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. —	
17. INFORMANT A. WHITE				ADDRESS SINAI HOSP.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE Hyaline Membrane Disease DUE TO, OR AS A CONSEQUENCE OF:					
(B) Prematurity DUE TO, OR AS A CONSEQUENCE OF:					
(C) —					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 36 hrs					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6.10.72 19 72 to 6.12 19 72 that (I) (we) last saw the deceased alive on 6.12 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Angela White M.B.A.				23B. DATE SIGNED 6.12.72	
23C. PHYSICIAN'S NAME (Type) ANGELA WHITE				23D. ADDRESS SINAI HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6-30-72		24C. NAME OF CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT AUG 17 1972		25B. NAME OF REGISTRAR Indy...		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL	
VS 150-REV. 1/1/68					

MORTUARY SERVICE - BCHD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		STATE OF MARYLAND - DEPT. OF HEALTH REG. NO. 72 07821
1. NAME OF DECEASED (Type or Print) MUZIK, FRANK JOSEPH		2. DATE AND HOUR OF DEATH 8 11 72 8:12 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL, BALTO., MD.		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY ANN ARUNDEL
5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years last birthday) 66 YRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET/MACHINIST		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME JOSEPH MUZIK		14. MOTHER'S MAIDEN NAME KATHERINE (ZEMON)
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214 01 4857
17. INFORMANT BALTIMORE, MD.		18. CAUSE OF DEATH Irene Muzik 100 8th Avenue
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Perforated bowel & Peritonitis		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Broncho pneumonia.
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II		21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Pericarditis
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED YES
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ST. AGNES HOSPITAL, WILKENS & CATON AVE.
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? Perforated bowel & Peritonitis
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7 31 19 71 to 8 11 19 72 . that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/11 19 72 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.		
23A. SIGNATURE Thien Thitivarana		23B. DATE SIGNED 08/12/72
23C. PHYSICIAN'S NAME (Type) THIEN THITIVARANA, M.D.		23D. ADDRESS BALTO. MD. 21229 ST. AGNES HOSPITAL, WILKENS & CATON AVE.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/15/72	24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery
24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972
25B. NAME OF REGISTRAR George J. Gonce		25C. FUNERAL DIRECTOR ADDRESS 4001 Ritchie Hwy

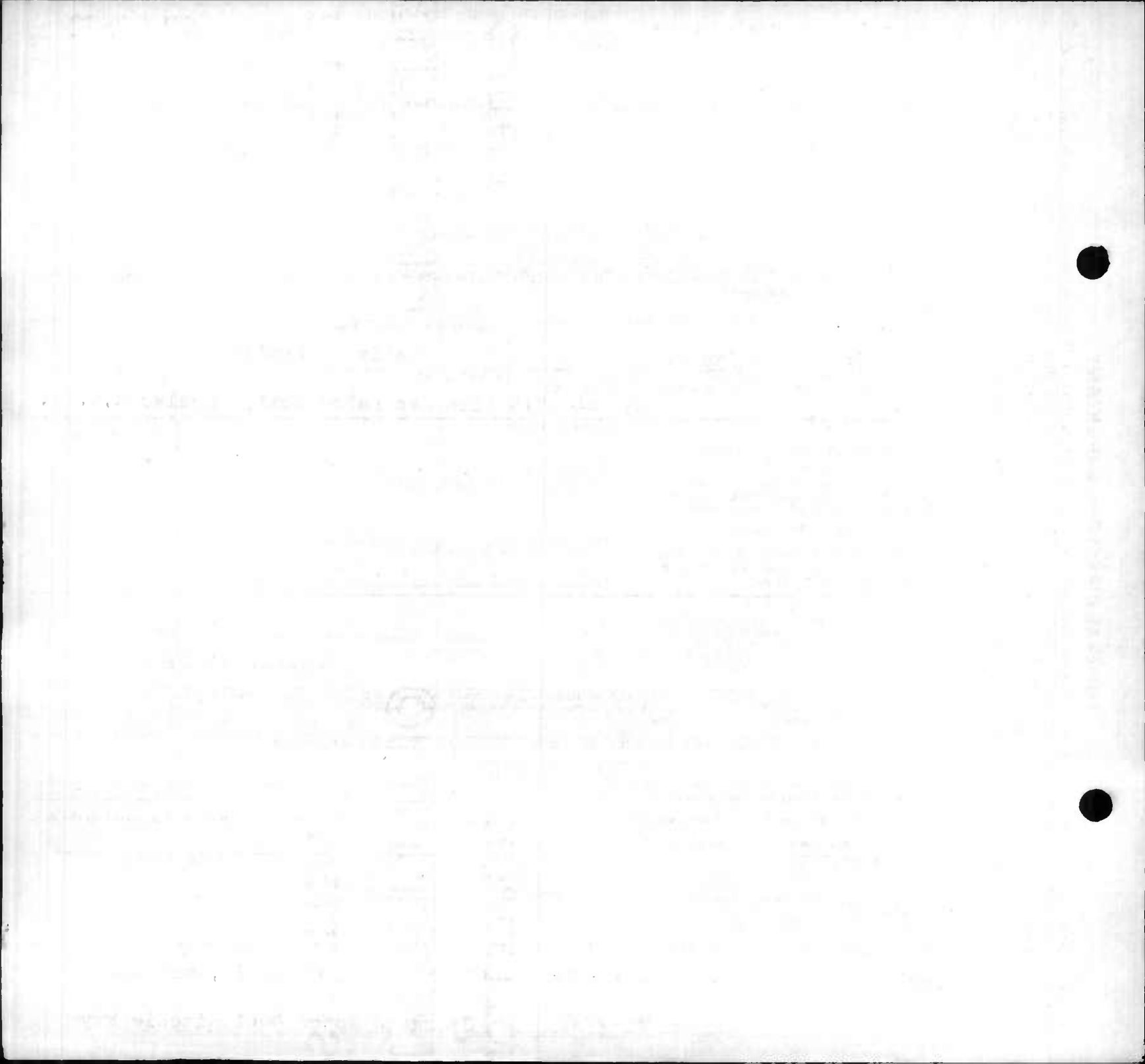
ST. JAMES HOSPITAL, WILKINS & CLARK AVE.
BALTIMORE, MARYLAND
CELESTINE

THE NEW THIRTYSECOND, N.Y.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-550 72 07822		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07822	
BIRTH NO.		STATE OF MARYLAND-DEPT		M.	
1. NAME OF DECEASED (Type or Print) <u>M. Fred W. Bowman</u>		2. DATE AND HOUR OF DEATH <u>Aug 11 1972</u> <u>4:45 P</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u> <u>33</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>W. Linthicum</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u> 6. RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/19/32</u> 9. AGE (in years last birthday) <u>39</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Own Tavern</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William M Whitaker</u>		14. MOTHER'S MAIDEN NAME <u>Della Pruitt</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>234 44 9714</u>		17. INFORMANT ADDRESS <u>Ella Mae LaFon Box 132 Coalwood, W. Va.</u>	
18. <u>571.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Arrest</u> (B) <u>Poss. Pulm Embolism</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>3 days post op Meso-Caval Shunt</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>45 min</u> <u>45 min</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>UGI bleeding from Esoph Varices 20 to 40 years Cirrhosis</u>					
19A. DATE OF OPERATION <u>8/8/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>UGI Bleeding - Esoph Varices</u>		20A. AUTOPSY? (Yes or No) <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE OID INJURY OCCURRED (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 8</u> 19 <u>72</u> to <u>Aug 11</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Aug 11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Bruce G. Farrell, M.D.</u>		DEGREE <u>MD</u> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/11/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Bruce G. Farrell</u>		23D. ADDRESS <u>Dept Surgery - Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/15/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Glen Burnie, Maryland</u>		(State) <u>Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 17 1972</u>		25B. NAME OF REGISTRAR <u>Sidney H. Boston</u>		25C. FUNERAL DIRECTOR ADDRESS <u>George J Gonce 4001 Ritchie Hwy</u>	



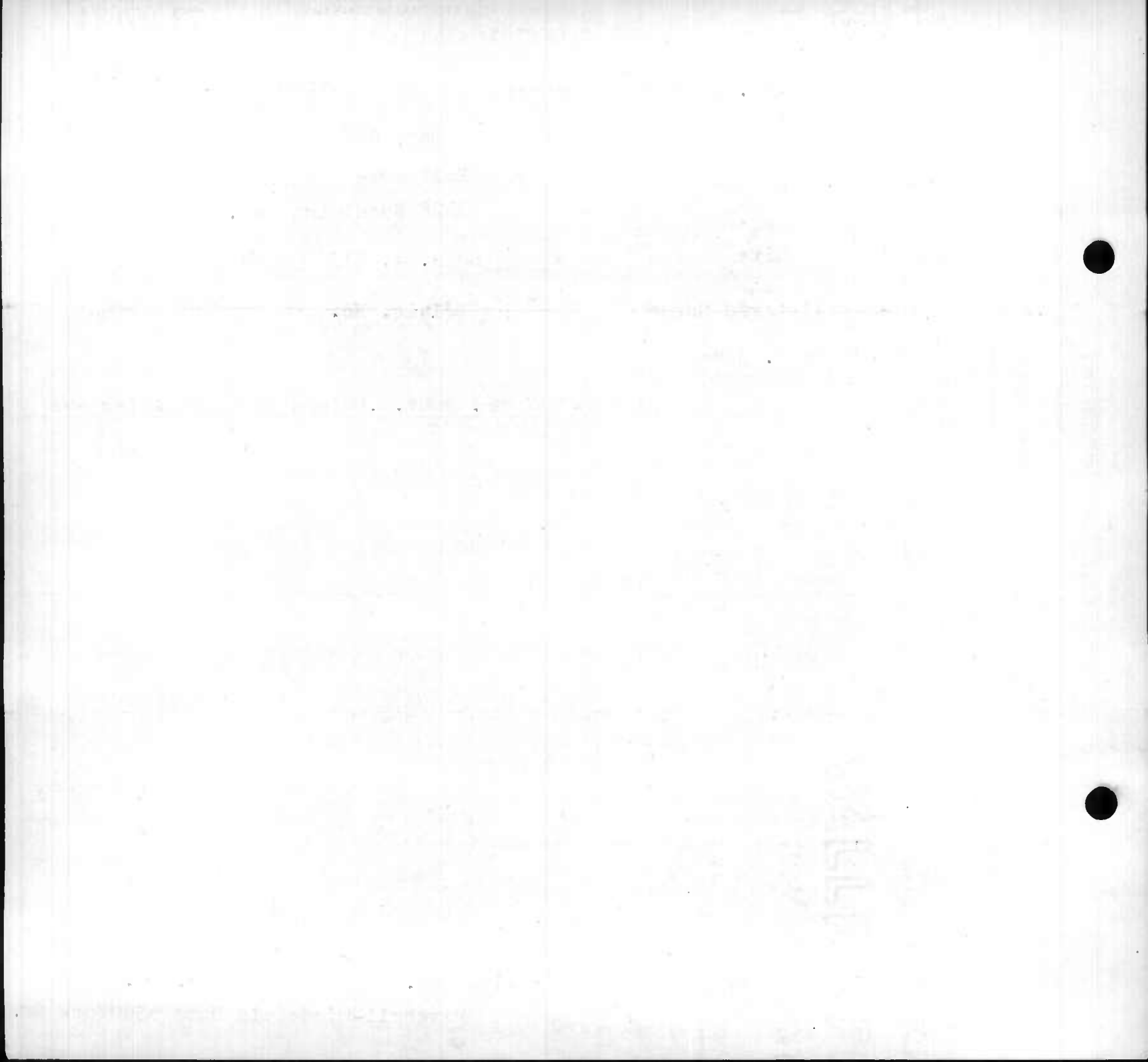
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 7-523		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07823	
1. NAME OF DECEASED (Type or Print) ZAMOSTNY, BRIDGET MARY		2. DATE AND HOUR OF DEATH AUGUST 11 1972 11:00A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL 40		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY ANNE ARUNDEL C. CITY OR TOWN RIVERA BEACH MD D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 8479 GARDEN RD 21122			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05 03 23	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME VINCENT DI LEONARDI			
14. MOTHER'S MAIDEN NAME CATHERINE (Leoni)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT WILKENS & CATON AVE ST. AGNES HOSPITAL RECORDS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 180X I CAUSE OF DEATH Jerome Zamostny 8479 Garden Rd		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE metastasis DUE TO, OR AS A CONSEQUENCE OF: (B) Carcinoma of cervix DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from AUGUST 10 1972 to AUGUST 11 1972 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on AUGUST 11 1972 and that in <input checked="" type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 8-11-72		23C. PHYSICIAN'S NAME (Type) SUNG E. KIM	
23D. ADDRESS ST. AGNES Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 8/14/72		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972		25B. NAME OF REGISTRAR Sidney [Signature]		25C. FUNERAL DIRECTOR George J Gonce	
25D. ADDRESS 4001 Ritchie Highway					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

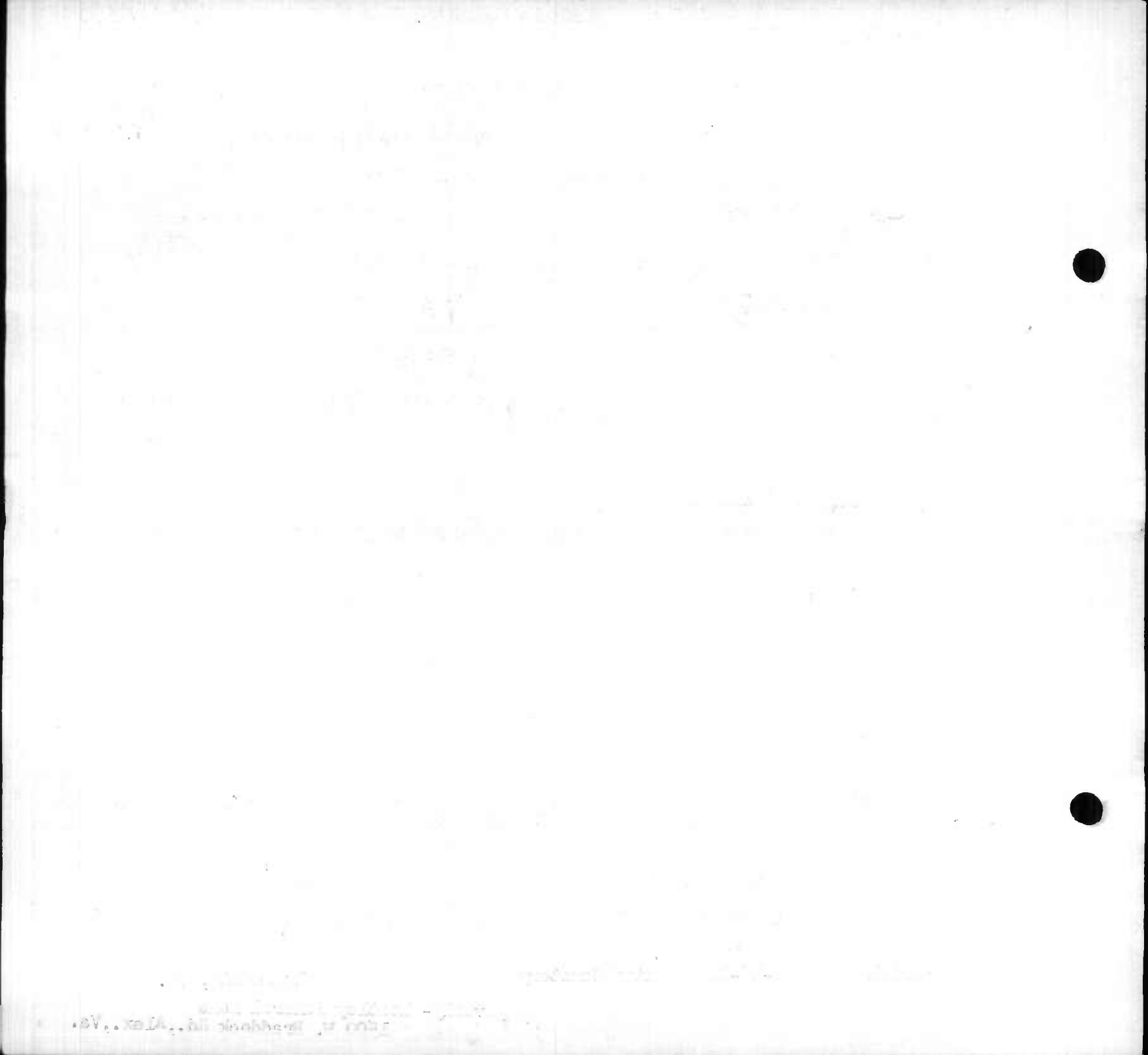
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07824	
0-528 72 07824				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mrs. Anna Mae Owings		August 13, 1972 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3328 Spaulding Ave 00				A. STATE Maryland	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3328 Spaulding Ave.	
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1915		9. AGE (In years last birthday) 56
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Belair, Md.	
13. FATHER'S NAME Benjamin F. Jones		14. MOTHER'S MAIDEN NAME ?		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-30-2678		17. INFORMANT Mr. Robt.H.Owings	
				ADDRESS 3328 Spaulding Ave	
18. 183.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Diffuse carcinomatosis DUE TO, OR AS A CONSEQUENCE OF: (B) Ovarian carcinoma DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several months 1 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1966 to Aug 13 19 72 , that (I) (we) last saw the deceased alive on Aug 13 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Seymour H. Rubin				23B. DATE SIGNED 8/14/72	
23C. PHYSICIAN'S NAME (Type) SEYMOUR H. RUBIN				23D. ADDRESS 3415 PARK HEIGHTS RD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/72		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cem.	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972		25B. NAME OF REGISTRAR Lidney		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home	
				ADDRESS 6500 York Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07825	
CERTIFICATE OF DEATH				REG. NO. 72 07825	
U-523		72 07825			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WINGATE Mys ELIZABETH		2. DATE AND HOUR OF DEATH 8/13/72 2:15 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME Hospital		A. STATE NEW HAMPSHIRE.			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 BALTIMORE.		C. CITY OR TOWN SALEM.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4-15-87		9. AGE (In years last birthday) 85.		10. Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VA	
12. CITIZEN OF WHAT COUNTRY? AMER.		13. FATHER'S NAME RICHARD FLETCHER.		14. MOTHER'S MAIDEN NAME ISABELLE MALLS.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-22-9834		17. INFORMANT GRACE PEATE	
18. CAUSE OF DEATH		ADDRESS II CYPRESS ST SALEM			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Corio pulmonary Appt		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 mts.	
(B) Congestive Heart Failure.		DUE TO, OR AS A CONSEQUENCE OF:		Since 1 wk.	
(C) Progressive, in nature					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8/9/19 72 to 8/13/19 72		that (I) (we) last saw the deceased alive on 8/13/19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE L. Padmarasu M.D.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) Dr. L. PADMARASU. M.D.	
23D. ADDRESS CHURCH HOME Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-16-72	
24C. NAME OF CEMETERY or CREMATORY Union Cemetery		24D. LOCATION (City, town, or county) (State) Alexandria, Va.		25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972	
25B. NAME OF REGISTRAR Adrienne W. ...		25C. FUNERAL DIRECTOR Everly-Wheatley Funeral Home		ADDRESS 21500 W. Braddock Rd., Alex., Va.	

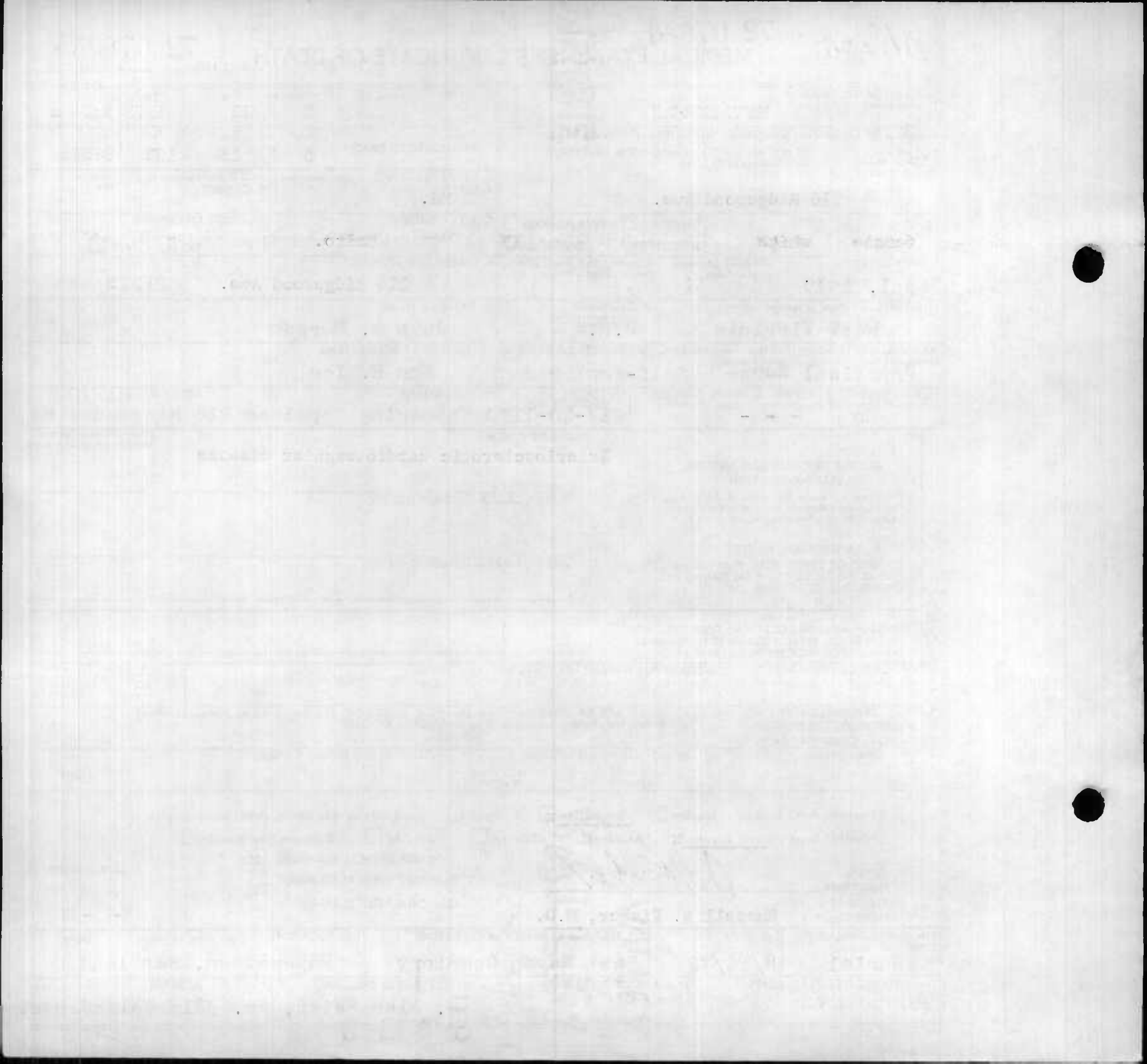


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY MORGAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 8 13 1972 9:34 a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 216 Ridgewood Ave.		3. DATE PRONOUNCED DEAD Month Day Year 8 13 1972 9:35a M.	
6. SEX female		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Sep 1, 1910		10. AGE (in years last birthday) 61	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		14B. KIND OF BUSINESS OR INDUSTRY Self-employed	
15. MOTHER'S MAIDEN NAME Ann E. Ice		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 217-40-1100		18. INFORMANT Katherine Copeland	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-14-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/72	
24C. NAME OF CEMETERY or CREMATORY Rest Haven Cemetery		24D. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972		25B. NAME OF REGISTRAR Sidney Johnson	
25C. FUNERAL DIRECTOR A. Alan Seitz, Jr.		ADDRESS 3818 Roland Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07827

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 07827

STATE OF MARYLAND - DHRM

K-613 72 07827

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print) BELLE KRAVETZ

2. DATE AND HOUR OF DEATH
8/13/72 11 45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
SINAI HOSP. OF BALTO

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY _____

C. CITY OR TOWN BALTO

D. INSIDE CITY LIMITS? YES ☒ NO ☐

E. STREET AND NUMBER 3916 FORDLEIGH RD

5. SEX FEMALE

6. RACE WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 1/15/01

9. AGE (In years last birthday) 71

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY AT HOME

11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME LOUIS M. ROSEN

14. MOTHER'S MAIDEN NAME KATE GOLDSTEIN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. 216-32-5665

17. INFORMANT MR. JOSEPH SPECTOR, SUITE 1010 ADDRESS 1 CHARLES CENTER #21201

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CA OF BRAIN

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mo.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: _____

(B) DUE TO, OR AS A CONSEQUENCE OF: _____

(C) _____

II. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION NONE

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____

20A. AUTOPSY? (Yes or No) _____

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? _____

22. I certify that (I) (this hospital) attended the deceased from 7/24 1972 to 8/13/72 1972 that (I) (we) last saw the deceased alive on 8/13/72 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Robert S. London, MD OEGREE

23B. DATE SIGNED 8/13/72

23C. PHYSICIAN'S NAME (Type) ROBERT S. LONDON, M.D. OEGREE

23D. ADDRESS SINAI HOSP. OF BALTO

24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL

24B. DATE 8/15/72

24C. NAME OF CEMETERY or CREMATORY BNAI ISRAEL

24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972

25B. NAME OF REGISTRAR Sidney Levinson

25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

VS 150-REV. 1/1/68

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>G-431 72 07828</p> <p style="text-align: center;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 07828</p> <p>STATE OF MARYLAND-DHMH</p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) CAROLYN GOLDBERG</p>		<p>2. DATE AND HOUR OF DEATH</p> <p>8/13/72 11:20 A.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>SINAI HOSP. OF BALTO</p>		<p>4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)</p> <p>A. STATE MD. B. COUNTY BALTO</p> <p>5. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>6. STREET AND NUMBER 6617 EBERLE DR., APT. 303</p>	
<p>5. SEX FEMALE</p>	<p>6. RACE WHITE</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 11/27/99</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY AT HOME</p>	
<p>11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME MOSES ROSENSTEIN</p>		<p>14. MOTHER'S MAIDEN NAME MARY MANDELBERG</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. 215-18-3486A</p>	
<p>17. INFORMANT HARRY GOLDBERG</p>		<p>ADDRESS 6617 EBERLE DR. APT. 303 #21215</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>LYMPHOSARCOMA - METASTATIC</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years</p>	
<p>19A. DATE OF OPERATION NONE</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) NONE</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) NONE</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 7/5/72 to 8/13/72 that (I) (we) last saw the deceased alive on 7/13/72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Robert S. London, MD</p>		<p>23B. DATE SIGNED 8/13/72</p>	
<p>23C. PHYSICIAN'S NAME (Type) ROBERT S. LONDON, MD</p>		<p>23D. ADDRESS SINAI HOSP BALTO</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL</p>	<p>24B. DATE 8/15/72</p>	<p>24C. NAME of CEMETERY or CREMATORY BALTIMORE HEBREW</p>	<p>24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND</p>
<p>25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972</p>		<p>25B. NAME OF REGISTRAR</p>	
<p>25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</p>		<p>ADDRESS</p>	

Handwritten notes and signatures, including the name "W. H. H. H." and the date "1/1/1912".

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07829	
72 07829				STATE OF MARYLAND - DHMH	
BIRTH NO. S-162		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SONIA SAPPERSTEIN			2. DATE AND HOUR OF DEATH AUGUST 14, 1972 6 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL (If not in hospital or institution, give street address or location) 42			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2831		
5. SEX FEMALE			6. RACE WHITE		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH MAY 18, 1918		
9. AGE (In years lost birthday) 54			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME PHILLIP KANOW			14. MOTHER'S MAIDEN NAME ROSE SCHWARTZ		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 212-28-7714		
17. INFORMANT MR. MYER SAPPERSTEIN, 6948 GLENHEIGHTS RD. #15			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 410.9 I Coronary Occlusion			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-11 1972 to 8-14 1972 .		that (I) (we) last saw the deceased alive on 8-11 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (do) (did not) view the body after death.			
23A. SIGNATURE Irvin Sauber			23B. DATE SIGNED 8/14/72		
23C. PHYSICIAN'S NAME (Type) IRVIN SAUBER			23D. ADDRESS 6905 PARK HEIGHTS AVENUE		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/15/72		24C. NAME of CEMETERY or CREMATORY BETH YEHUDA ANSHE KURLAND	
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972			
25B. NAME OF REGISTRAR Sol Levinson		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

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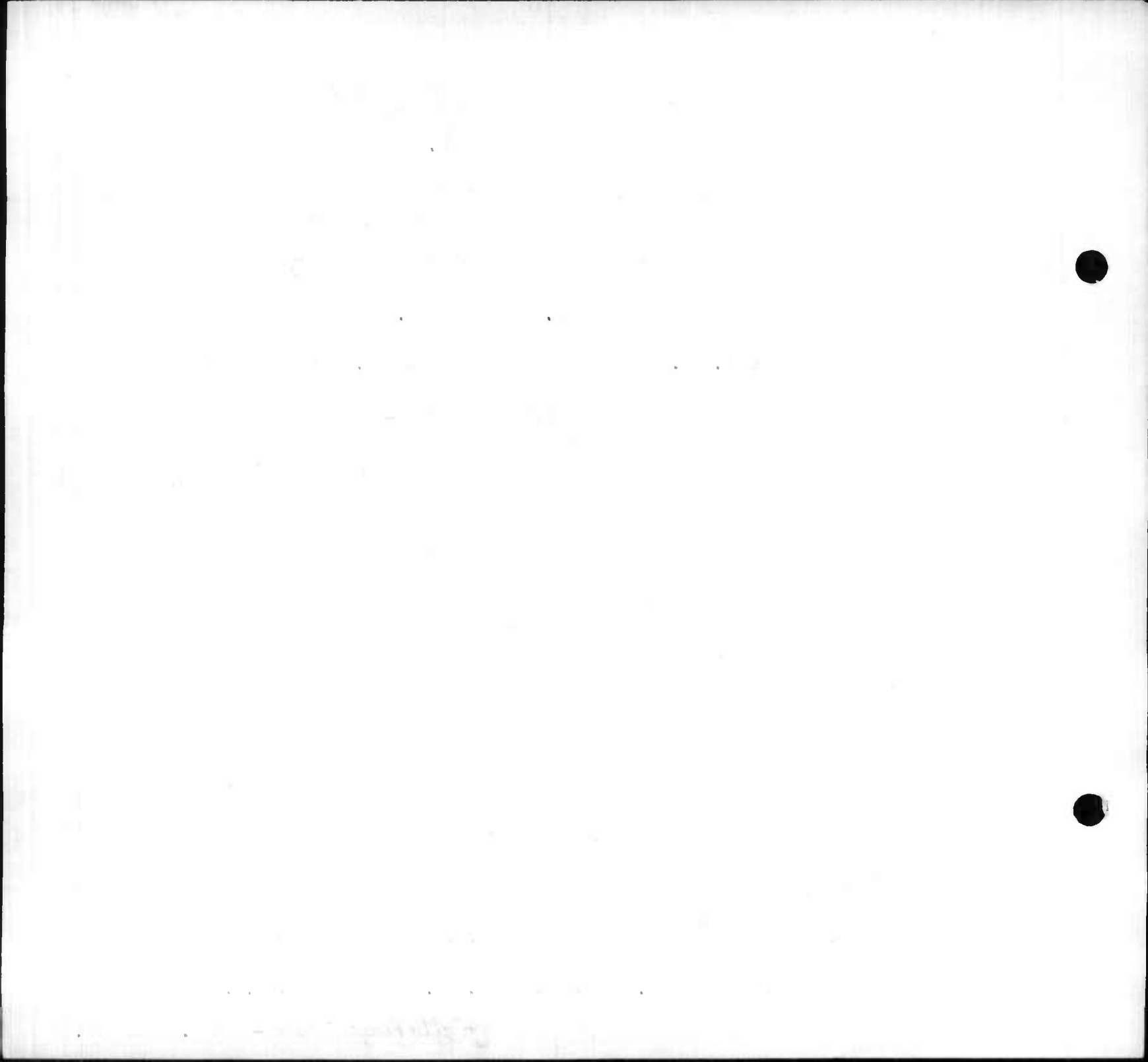
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 07830 CERTIFICATE OF DEATH				REG. NO. _____	
BIRTH NO. <u>W-635</u>				72 07830	
1. NAME OF DECEASED (Type or Print) <u>James Lewis Wroten</u>				2. DATE AND HOUR OF DEATH <u>8/14/72</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 406 East Fort Avenue</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2402</u>	
5. SEX <u>M</u>		6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/10/12</u>	9. AGE (In years last birthday) <u>59</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>American Oil Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>Edward J. Sn.</u>				14. MOTHER'S MAIDEN NAME <u>Elsie M. Belt</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW # 11 215 01 2713</u>		17. INFORMANT <u>Family - Same</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>160.2 I</u> <u>Carcinoma (L) maxilla</u> <u>Antrum</u> <u>None</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 4</u> 19 <u>72</u> to <u>Aug 7, 1972</u> that (I) (we) last saw the deceased alive on <u>Aug 7, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Seymour Weiner M.D.</u>				23B. DATE SIGNED <u>16 Aug 72</u>	
23C. PHYSICIAN'S NAME (Type) <u>S. WEINER</u>				23D. ADDRESS <u>UNIV. HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>8/18/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Geo. Washington Mem. Pk.</u>	
24D. LOCATION <u>Paramus, N.J.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 17 1972</u>			
25B. NAME OF REGISTRAR <u>Lidney H. Wroten</u>		25C. FUNERAL DIRECTOR <u>McCully Funeral Home - 130 E. Fort Ave.</u>			



G-532

72 07831 STATE OF MARYLAND-DHMT
BALTIMORE CITY HEALTH DEPARTMENT

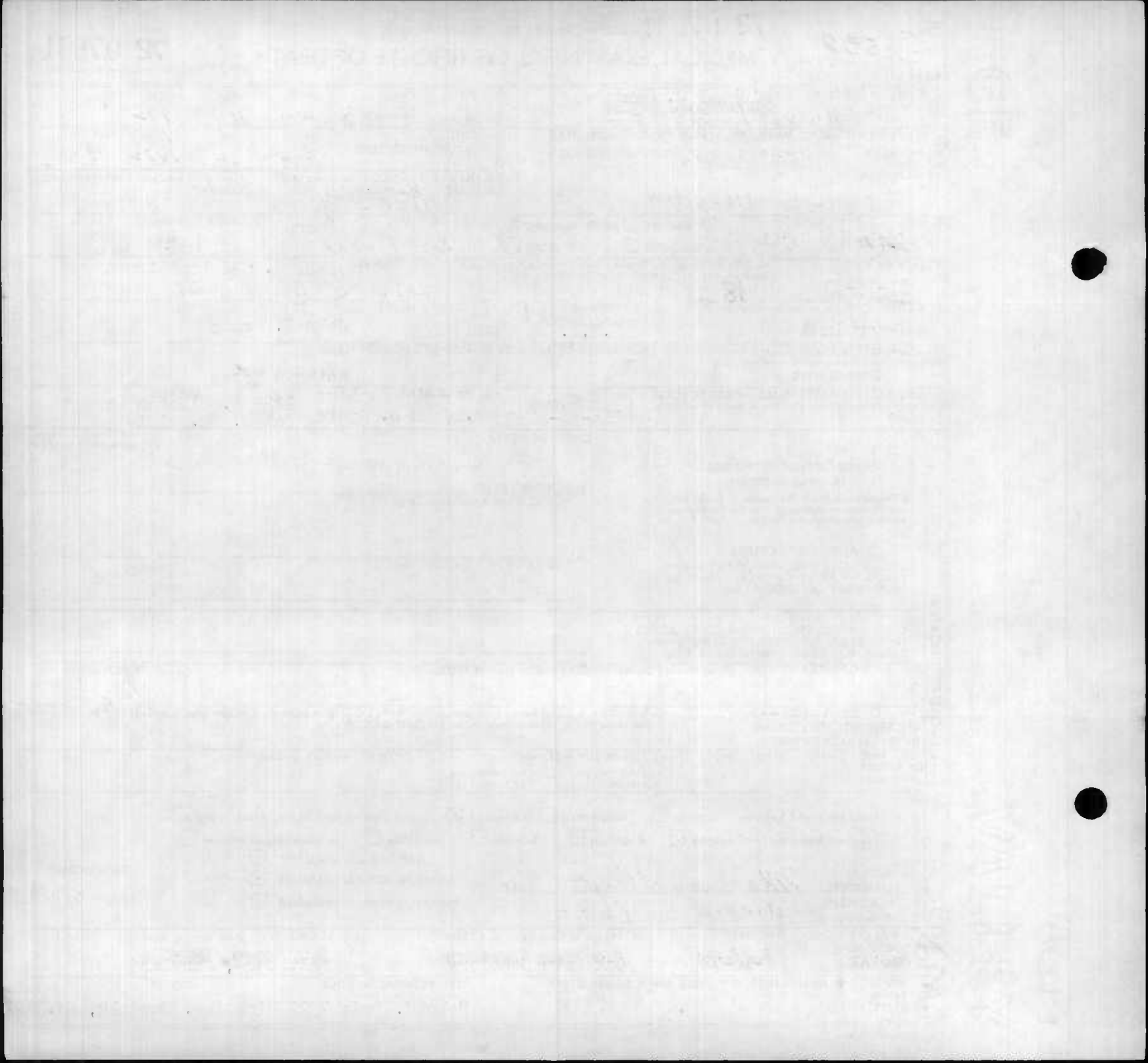
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07831

BIRTH NO.

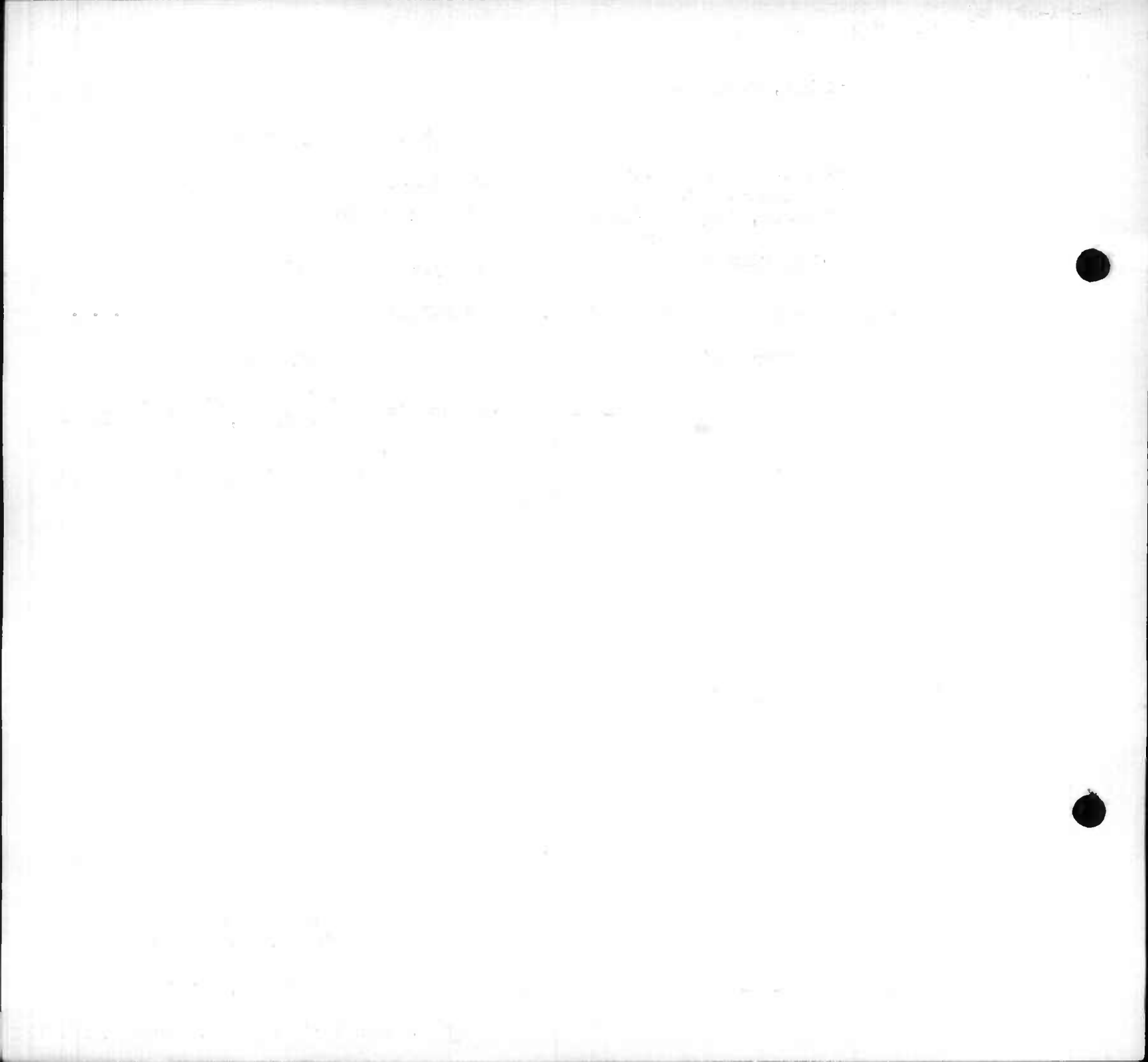
1. NAME OF DECEASED (Type or Print) Michael J. Gantz <i>Michael Gantz</i>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> Aug 12, 1972		Month Aug	Day 12	Year 1972	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 City Hospital		3. DATE PRONOUNCED DEAD Aug 12, 1972 9 30 A.M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2611			
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 11-15-53		10. AGE (In years last birthday) 18 yrs.		E. STREET AND NUMBER 1221 S. Clinton Street <i>1221 S. Clinton St.</i>			
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John S. Gantz			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Kathryn Moses			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-58-8253		18. INFORMANT Father: Mr. John S. Gantz ADDRESS 1221 S. Clinton Street Balto. Md. 21224			
19. 304.9		CAUSE OF DEATH Intravenous Narcotism				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)					
20A. DATE OF OPERATION 1		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt DATE SIGNED Aug 13, 1972							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-16-72		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972		25B. NAME OF REGISTRAR Lidney Whitson		25C. FUNERAL DIRECTOR ADDRESS John J. Duda 7922 Wise Ave. Dundalk, Md. 21222			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07832		REG. NO. 72 07832	
K-120							
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) Kaiphas, Joseph J				2. DATE AND HOUR OF DEATH Aug. 12/72 2:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? Baltimore YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 95 Wise Avenue							
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/24/05	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Production		10B. KIND OF BUSINESS OR INDUSTRY Beth Steel Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Kaiphas				14. MOTHER'S MAIDEN NAME Kunigunda Neuberger			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-5931		17. INFORMANT ADDRESS BCH Records 4904 Eastern Avenue Baltimore, Maryland 21214			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE <u>Brown tumor (osteocytoma)</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Left temporal lobe</u>							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION Aug 3/1972		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED meniscus cross neck		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/26 19 72 to Aug 12 19 72 that (I) (we) last saw the deceased alive on Aug 12 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. SARKARATI				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) MEHDI SARKARATI M.D.				23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 8-16-72		24C. NAME of CEMETERY or CREMATORY Sacred Heart of Jesus		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR ADDRESS 2922 Wise Ave. Dundalk, Md. 21222			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-236		72 07833		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07833	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) CUSTEE, DORA E.				2. DATE AND HOUR OF DEATH 8/11/72 7PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION USPHS HOSPITAL 3100 WYMAN PARK DR BALTIMORE MD				C. CITY OR TOWN Catonsville		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 6 Glenwood Ave.							
5. SEX F	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 29 1937	9. AGE (In years last birthday) 35	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY AT Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Deavers				14. MOTHER'S MAIDEN NAME DORA HEBER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 214-34-4393		17. INFORMANT Francis Custer		
			ADDRESS 6 Glenwood Ave. Catonsville, Md 21228				
18. 238.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CARDIORESPIRATORY Arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. BRAIN TUMOR							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from MARCH 19 72 to Aug 1972 that (I) (we) last saw the deceased alive on Aug 11 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph Aisner MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/11/72	
23C. PHYSICIAN'S NAME (Type) JOSEPH AISNER M.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-14-72		24C. NAME OF CEMETERY OR CREMATORY Good Shepherd		24D. LOCATION (City, town, or county) (State) Ellicott City Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972		25B. NAME OF REGISTRAR Linda H. Johnson		25C. FUNERAL DIRECTOR ADDRESS Shack F.H. Ellicott City, Md. 21043			

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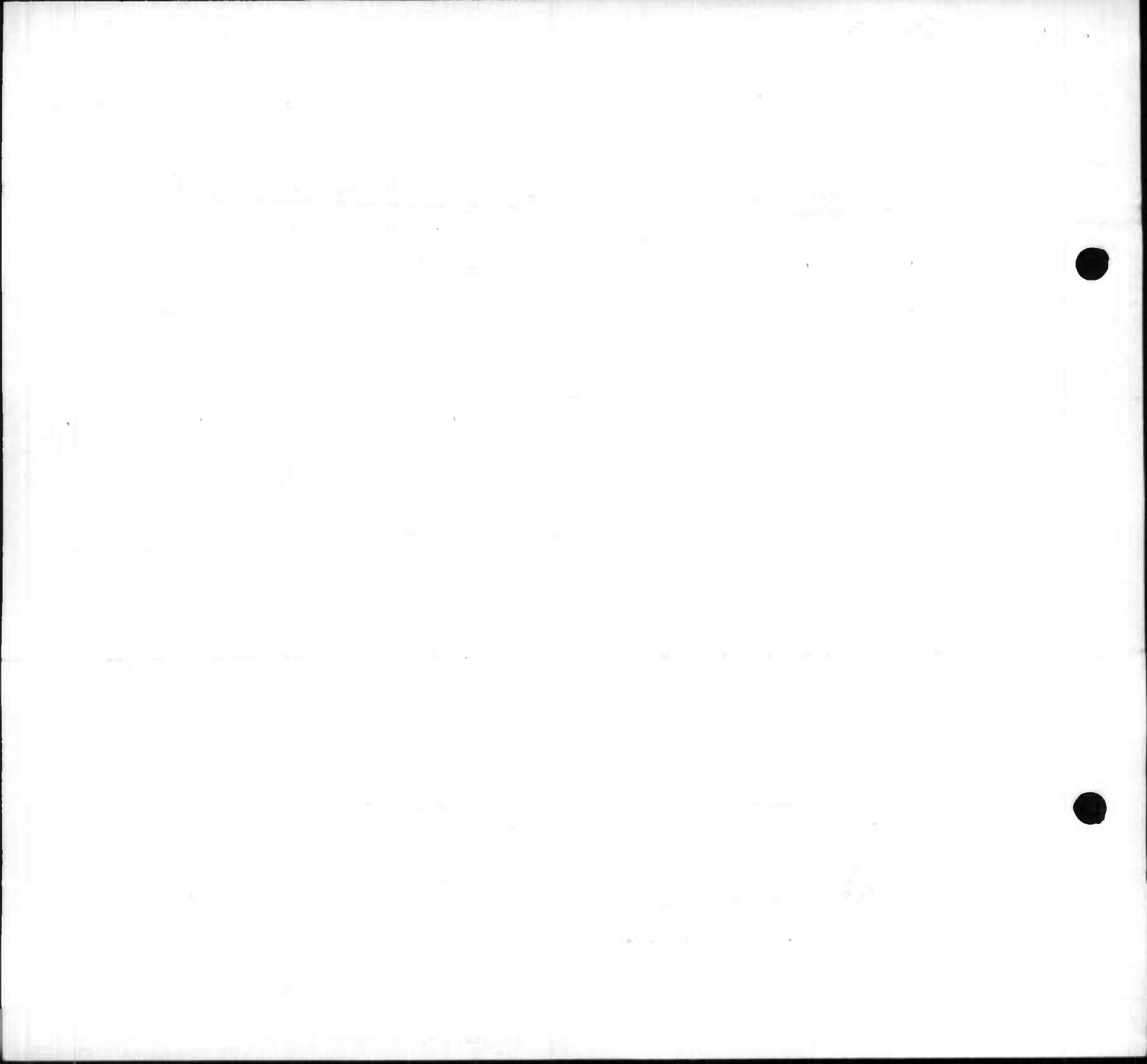
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

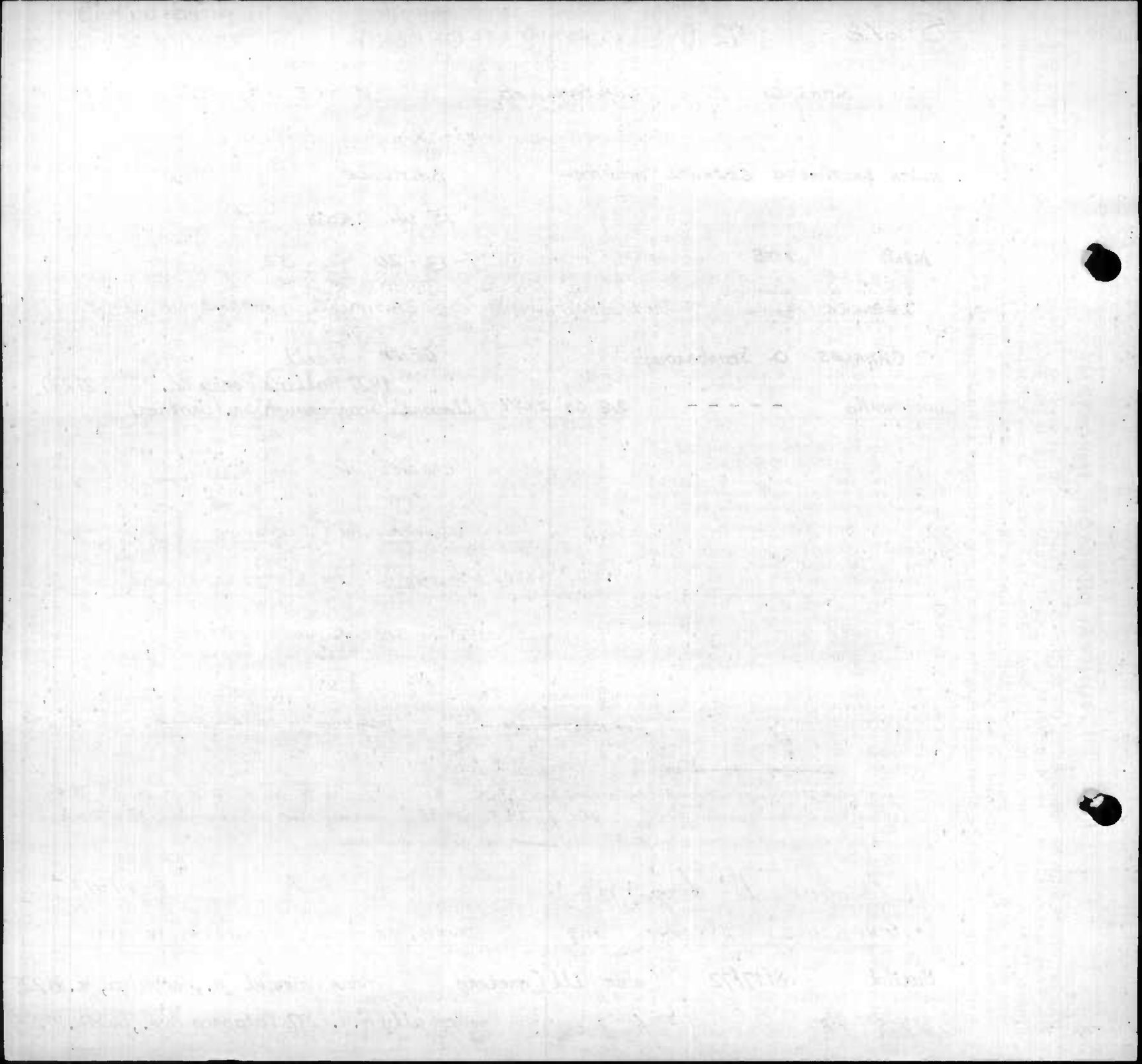
<div style="display: flex; justify-content: space-between;"> G-356 72 07834 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		<div style="display: flex; justify-content: space-between;"> REG. NO. 72 07834 </div>	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Walter C. Getner</u>		2. DATE AND HOUR OF DEATH <u>August 15, 1972</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Gould Nursing Home</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>102</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>32 S. Curley Street</u>	
5. SEX <u>M.</u>	6. RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/28/189</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Sears Roebuck</u>	
13. FATHER'S NAME <u>Jacob Getner</u>		14. MOTHER'S MAIDEN NAME <u>Sophia ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>276-3354A</u>	
18. <u>4/12-3</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		17. INFORMANT ADDRESS <u>Mrs. Bennetta Getner 32 S. Curley St.</u>	
18. <u>4/12-3</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>yes</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>2/25/1971</u> to <u>8/15/1972</u> and that (I) <u>we</u> last saw the deceased alive on <u>2/27/1972</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>Walter C. Getner</u> (did not) view the body after death.		20A. AUTOPSY? (Yes or No)	
23A. SIGNATURE <u>Albert B. Bradley</u>		23B. DATE SIGNED <u>8/16/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Albert B. Bradley, M.D.</u>		23D. ADDRESS <u>4900 Belair Road 21206</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/17/72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 17 1972</u>		25B. NAME OF REGISTRAR <u>Liddy J. Wilson</u>	
25C. FUNERAL DIRECTOR <u>John A. Moran, Inc.</u>		ADDRESS <u>300 E. Baltimore St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

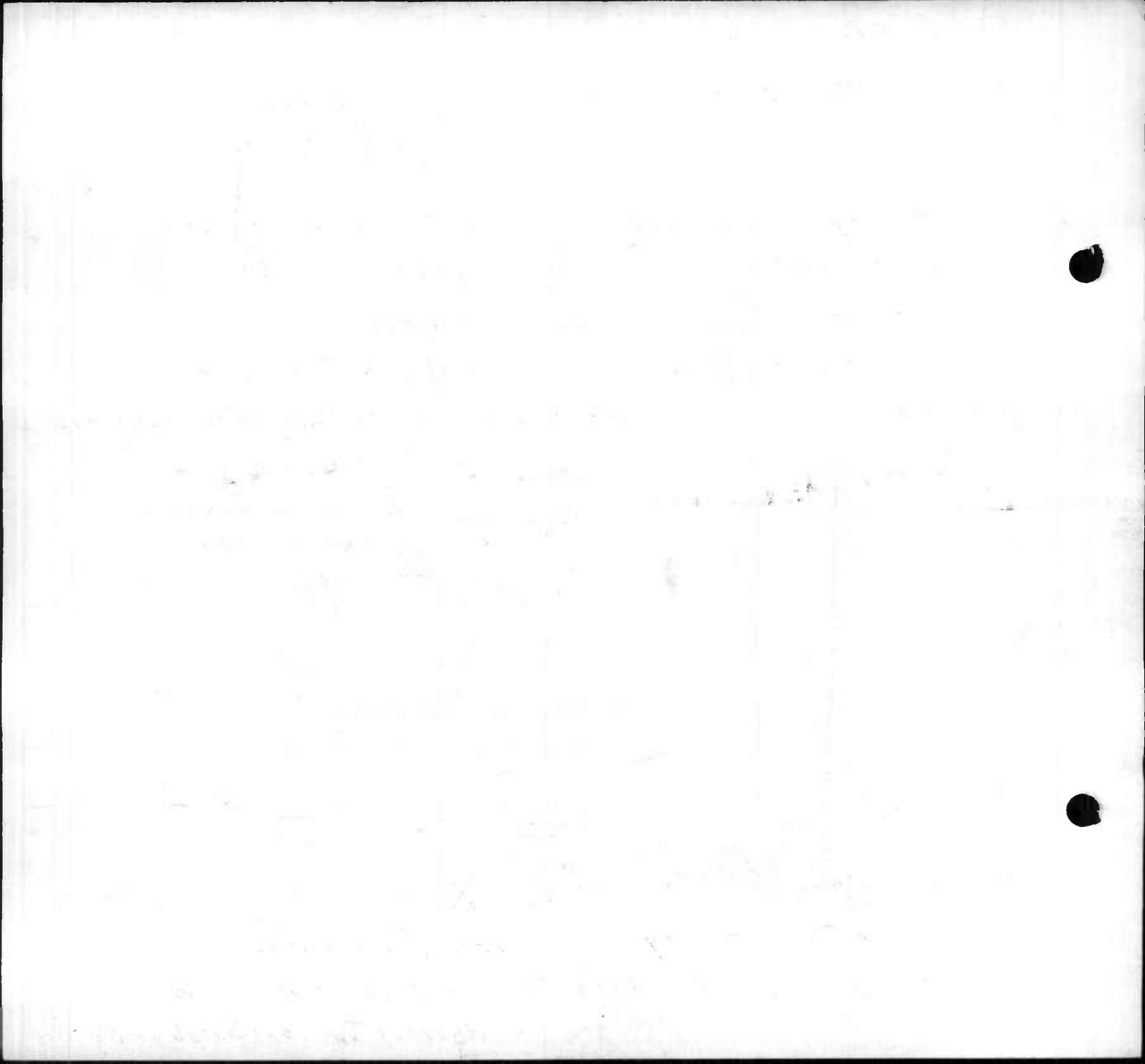
BALTIMORE CITY HEALTH DEPARTMENT				72 07835		72 07835		STATE OF MARYLAND-DHMH	
S-616		72 07835		BALTIMORE CITY HEALTH DEPARTMENT		72 07835		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print)		CHARLES R. SCARBOROUGH		2. DATE AND HOUR OF DEATH		AUGUST 14, 1972		10:15 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL 43				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		BALTIMORE CITY	
				C. CITY OR TOWN		BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER		15 W. CROSS ST.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. BIRTHPLACE (State or foreign country)	11. CITIZEN OF WHAT COUNTRY?			
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7-13-20	52	BALTIMORE MARYLAND	U.S.A.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
LABORER (SEALER)				BOX MANUFACTURING		BALTIMORE MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
CHARLES O. Scarborough				DENA ? Marll		UNKNOWN No		218-03-2257	
17. INFORMANT				1927 Hollins Ferry Rd.		ADDRESS		21230	
				Ellsworth Scarborough Sr. (Brother)					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE		CARDIOGENIC SHOCK		3-5 MINUTES	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:		VENTRICULAR ARRHYTHMIA		3-5 MINUTES	
				(C) DUE TO, OR AS A CONSEQUENCE OF:		ARTERIO SCLEROTIC CORONARY ARTERY DISEASE		AT LEAST 4 MONTHS	
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		POSSIBLE CHRONIC LUNG DISEASE			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				No.					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	
		HAMBURG + CHARLES ST.		HAMBURG + CHARLES ST.		8-14-72 10:00 AM		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
22. I certify that (s) (this hospital) attended the deceased from DEC 8 1971 to DEC 20 1971, that (s) (we) last saw the deceased alive on DEC 29 1972 and that (s) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (s) (We) (did) (did not) view the body after death.				23A. SIGNATURE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
				Theodore H. Cryer M.D.				8-14-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
THEODORE H. CRYER M.D.				SOUTH BALTIMORE GENERAL HOSPITAL		Burial		8/17/72	
24C. NAME OF CEMETERY OR CREMATORY				24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
Cedar Hill Cemetery				Anne Arundel Co., Brooklyn, Md. 21225		AUG 17 1972		A. J. [Signature]	
25C. FUNERAL DIRECTOR				25D. ADDRESS		25E. DATE REC'D BY HEALTH DEPT.		25F. NAME OF REGISTRAR	
McGulley F. H.				237 Patapsco Ave., Balto. 21225		AUG 17 1972		A. J. [Signature]	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

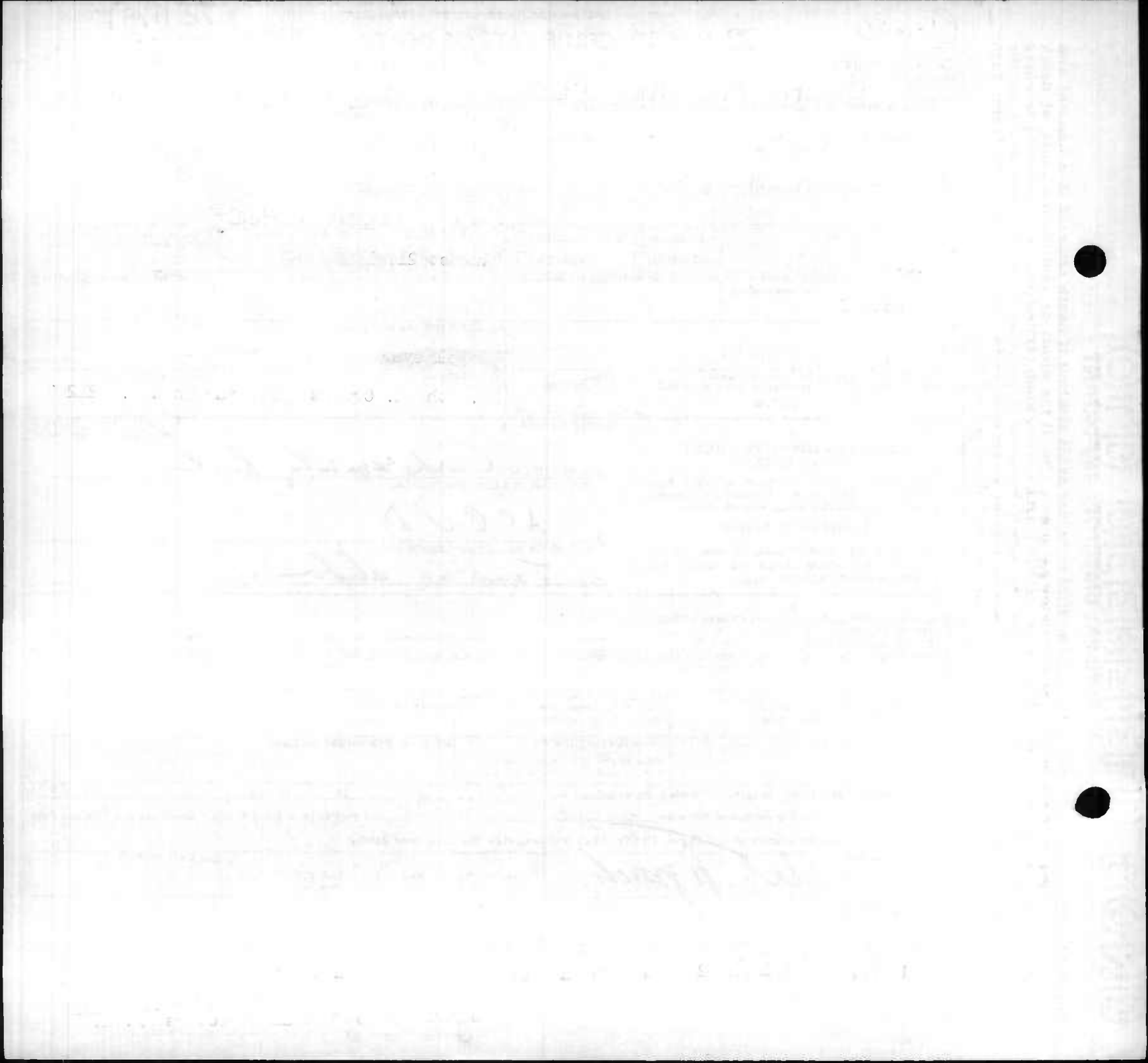
C-500		BALTIMORE CITY HEALTH DEPARTMENT		72 07836	CERTIFICATE OF DEATH	REG. NO. 72 07836	STATE OF MARYLAND-DHMH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Theodore I Chaney</i>		2. DATE AND HOUR OF DEATH <i>8/14/72</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN <i>Halethorpe</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Agnes Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>4607 Linden Ave.</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/14/08</i>	9. AGE (In years last birthday) <i>64</i>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Loader</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Oil Company</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>William A. Chaney</i>		14. MOTHER'S/MAIDEN NAME <i>Mabel V. Johnson</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-07-3212</i>	
17. INFORMANT <i>Margaret A. Chaney</i>		ADDRESS <i>4607 Linden Ave.</i>		18. CAUSE OF DEATH <i>Rheumatoid</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>myocardial infarction & asphyxia</i>	
(B) <i>Coronary Arteriosclerosis</i>		(C) <i>to the asphyxia</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 1960</i> to <i>8/14</i> 19 <i>72</i> and that I (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>John H. Healey</i>		23B. DATE SIGNED <i>8/15/72</i>		23C. PHYSICIAN'S NAME (Type) <i>Dr. John Healey</i>		23D. ADDRESS <i>1311 Francis Ave.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/18/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Louisa Park Cemetery, Baltimore Md.</i>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 17 1972</i>		25B. NAME OF REGISTRAR <i>Andrew J. Gordon</i>		25C. FUNERAL DIRECTOR <i>Andrew J. Gordon</i>		ADDRESS <i>1328 Sulphur Sp. Rd</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07837
72 07837 CERTIFICATE OF DEATH				STATE OF MARYLAND-DHME
1. NAME OF DECEASED (Type or Print) <u>Crooks, Mrs. Alice Florence</u>		2. DATE AND HOUR OF DEATH <u>Aug 14, 1972</u> <u>1:30</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> <u>34</u>		A. STATE <u>Maryland</u> B. COUNTY <u>2841</u>		
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>3605 Marmon Ave.</u>				
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 21, 1888</u> <u>83</u>	9. AGE (In years last birthday) <u>83</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Frank John Miller</u>		14. MOTHER'S MAIDEN NAME <u>Wilmeyer Buckingham</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>212-22-1204</u>		17. INFORMANT ADDRESS <u>Mr. Otho A. Crooks 3605 Marmon Ave. 21207</u>
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiorespiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ASCCVD.</u> (B) <u>ASCCVD.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Tumor of abdomen</u>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>9-9-72</u> 19 <u>72</u> to <u>Aug 14</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Aug 14</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>W. A. [Signature]</u>		23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/16/1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 17 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR ADDRESS <u>8728 Liberty Road</u> <u>21133</u> <u>Loring Byers, Funeral Directors, P. A.</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07838		REG. NO. 72 07838	
T-523				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MRS TOWNSEND LILLIAN				2. DATE AND HOUR OF DEATH 4 AM August 12-1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE M.D. B. COUNTY 301			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME & Hospital 100 N Broadway Baltimore Md				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9/15/81		9. AGE (In years lost birthday) 90 years	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School teacher				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Thomas Henry Reese				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No - - -				16. SOCIAL SECURITY NO. 214-24-2851		17. INFORMANT 51 Church Home Records	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiopulmonary arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASMD & Senility				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sajadi				23B. DATE SIGNED 8/13/72			
23C. PHYSICIAN'S NAME (Type) SAJADI M.D.				23D. ADDRESS CHURCH HOME & Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 15 AUG 72		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972		25B. NAME OF REGISTRAR Hidney		25C. FUNERAL DIRECTOR Howard Stung		ADDRESS 3207 W. North Av	

0/26/72

No Prev Address on file

with CH 4 H

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

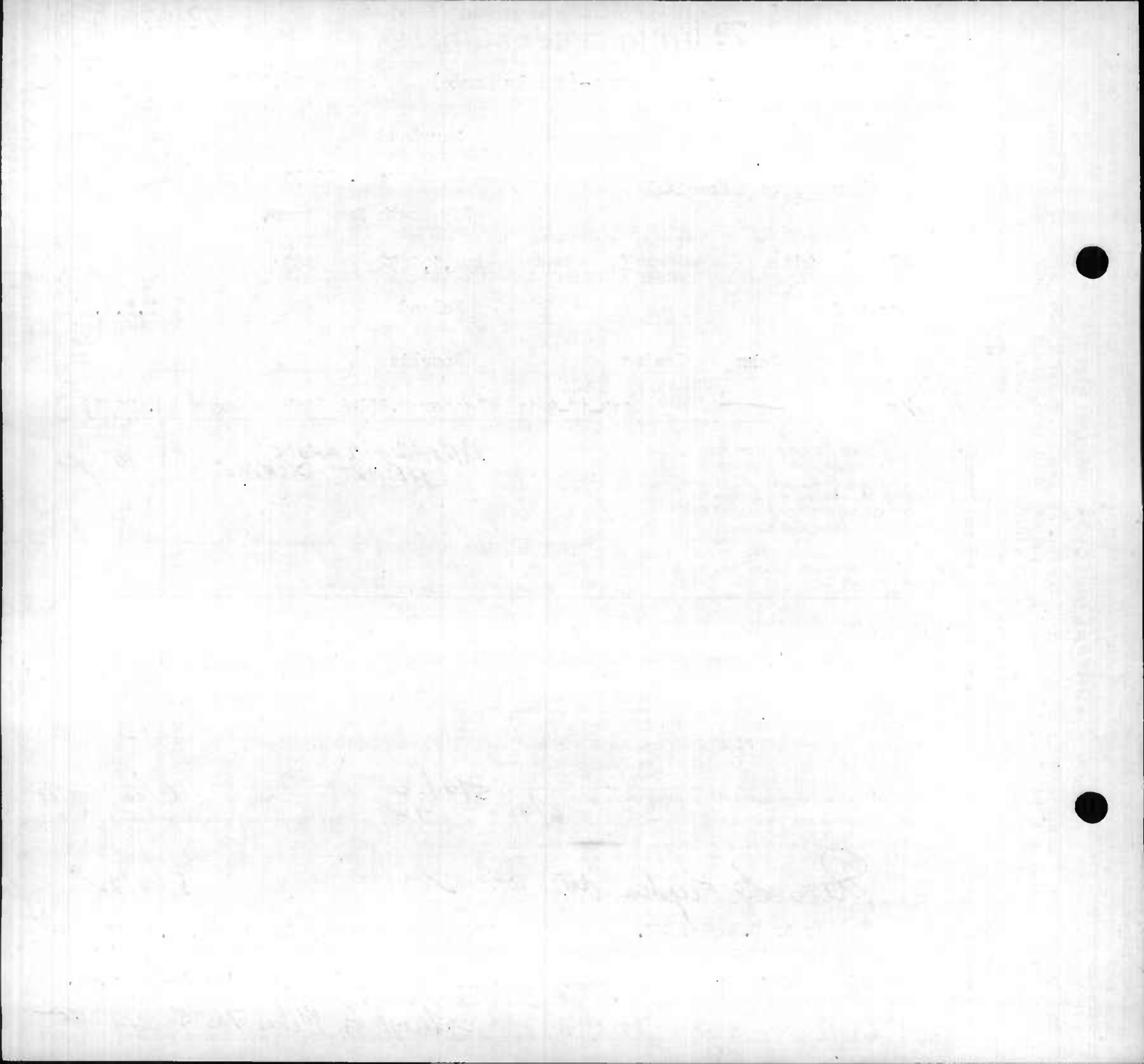
J-320		72 07839		BALTIMORE CITY HEALTH DEPARTMENT		72 07839	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Jadwiga Maka				8-14-72 4:50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
90 MT. SINAI Nursing Home 4613 Park Heights Ave Baltimore, Md. 21215				Maryland 2544			
C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER							
3815 Brookland Ave							
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	01-01-91	81			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
PACKER				LANGRAN CO.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Rachwal Maka				P			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				218-03-6267			
17. INFORMANT				ADDRESS			
John Maka				21225			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				2 days			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)							
ANTECEDENT CAUSES				4 weeks			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last				3 years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				None			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Aug 9 1972 to Aug 14 1972 that (I) (we) last saw the deceased alive on Aug 14 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Manuel Levin M.D.				Aug 14, 1972			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
MANUEL LEVIN M.D.				6101 PARK HTS AVE BALTO-15 MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		8-17-72		ST. STANISLAUS		6515 BOSTON ST. BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 17 1972		Andrew Johnson		KRAUSE FUNERAL HOME		1216 S. CHARLES ST.	

3815 BROOKLYN AVE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07840	
72 07840				STATE OF MARYLAND-DEATH	
BIRTH NO. D-630		1. NAME OF DECEASED (Type or Print) Angela Amelia Darda-(Aniela Darda)		2. DATE AND HOUR OF DEATH August 16, 1972 8 ⁰⁰ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		5. AGE (In years last birthday)	
FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home & Hospital		A. STATE Maryland		B. COUNTY 202	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore 21231		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 259 South Ann Street		6. DATE OF BIRTH Aug. 1, 1892		7. AGE (In years last birthday) 80	
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
13. FATHER'S NAME John Jasina		14. MOTHER'S MAIDEN NAME Rozalia ?		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-18-3811		17. INFORMANT ADDRESS Eleanor D. Piluk 3457 Dunhaven Rd. 21222	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTARIO SCLAROTIC HEART DISEASE		10 gm	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6/30 5:10/6 to 8/16 1972 and that (I) (we) lost saw the deceased alive on 6/30 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Irvin B. Kaplan MD				23B. DATE SIGNED 8/16/72	
23C. PHYSICIAN'S NAME (Type) Irvin B. Kaplan MD				23D. ADDRESS 129 South Broadway Baltimore, Md. 21231	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/19/72		24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery	
24D. LOCATION 7300 German Hill Rd-Balto, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972		25B. NAME OF REGISTRAR George A. Weber	
25C. FUNERAL DIRECTOR ADDRESS		25D. NAME OF REGISTRAR		25E. FUNERAL DIRECTOR ADDRESS	



G-660

72 07841

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07841

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph P. Greear		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 9 W. Preston Street		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 23 72 4:45 a. M.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Vineland	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 60		E. STREET AND NUMBER 2397 North East Blvd.	
11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? UNKNOWN	
13. FATHER'S NAME UNKNOWN		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE New Jersey B. COUNTY V27	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		14B. KIND OF BUSINESS OR INDUSTRY UNKNOWN	
15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN UNKNOWN	
17. SOCIAL SECURITY NO. UNKNOWN		18. INFORMANT MEDICAL EXAMINERS OFFICE	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Marvin Platt, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 7/23/72		ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL	
24A. BURIAL (CREMATION) REMOVAL (Specify)		24B. DATE 8/13/72	
24C. NAME of CEMETERY or CREMATORY Anatomy Bd		24D. LOCATION (City, town, or county) (State) Cullen	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972		25B. NAME OF REGISTRAR Sidney Johnston	
25C. FUNERAL DIRECTOR		25D. ADDRESS	

WALLEY
POLICE
OFFICE

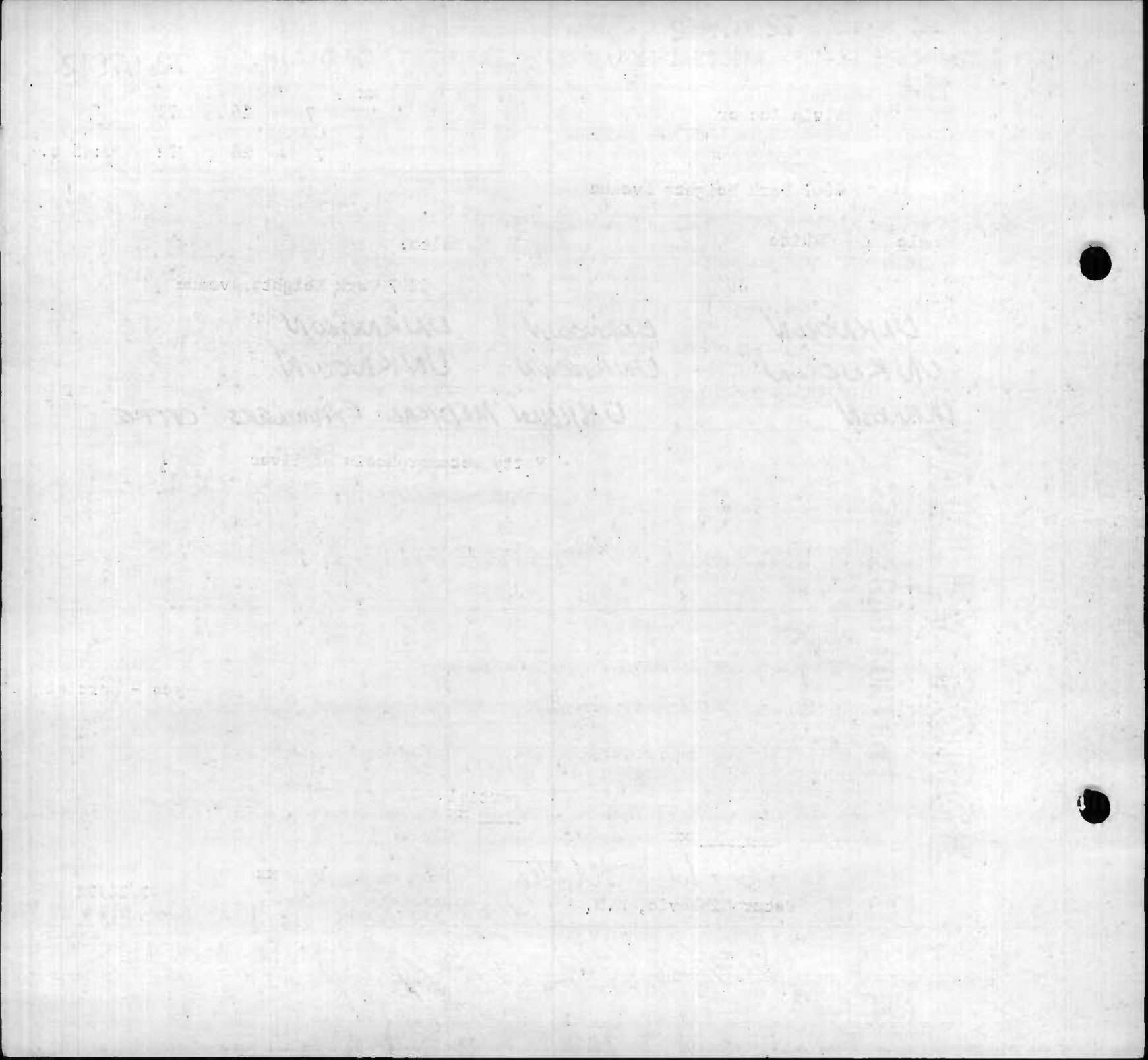
STATE OF MARYLAND-DEME
BALTIMORE CITY HEALTH DEPARTMENT

72 07842

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07842

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Alvin Zucker		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 7 Day 26 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 6807 Park Heights Avenue		3. DATE PRONOUNCED DEAD Month 7 Day 26 Year 72 Hour 8:45 a.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2730	
6. SEX male	7. RACE White	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH		10. AGE (In years lost birthday) 69	11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF UNKNOWN
13. FATHER'S NAME UNKNOWN		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		15. MOTHER'S MAIDEN NAME UNKNOWN	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown; if yes, give war or dates of service) UNKNOWN		17. SOCIAL SECURITY NO. UNKNOWN		18. INFORMANT MEDICAL EXAMINERS OFFICE	
19. CAUSE OF DEATH 571.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes - partial	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. NAME OF CEMETERY or CREMATORY Anatomy Bd.		24D. LOCATION (City, town, or county) (State) UNIVERSITY MEDICAL SCHOOL	
24A. BURIAL CREMATION REMOVAL (Specify) REMOVAL		24B. DATE 8/5/72		24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT AUG 17 1972		25B. NAME OF REGISTRAR Curran		25C. FUNERAL DIRECTOR Curran	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-400 1

72 07843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 07843

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LILLIAN HILL

2. DATE AND HOUR OF DEATH

8/15/72 3:15pm

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

PROVIDENT HOSPITAL
BALTIMORE, MD. 21205
2600 Liberty Hts.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

620 Pulaski St

5. SEX

Female

6. RACE

Negro

7. MARRIED

☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12-30-14

9. AGE (In years last birthday)

58

10. Under 1 Yr. Months Days

11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

RETIRED EMPLOYEE

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

JOHN

LASTER

14. MOTHER'S MAIDEN NAME

SOPHIE MATTHEWS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

911-19-3441

17. INFORMANT

SHIRLEY LASTER

ADDRESS

1929 Herbert St

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE SUBARACHNOID HGE.

(B) HYPERTENSION

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

8/15/72

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

TRACHEOSTOMY

20A. ANTOPTIC (Yes) or No

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/10/72 19 22 to 8/15 19 72 that (I) (we) last saw the deceased alive on 8/15/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Edgerton

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

8/15/72

23C. PHYSICIAN'S NAME (Type)

CONRADO E. AGUSTIN

23D. ADDRESS

Provident Hosp

24A. BURIAL CREMATION, REMOVAL (Specify)

Burned

24B. DATE

8/19/72

24C. NAME OF CEMETERY OR CREMATORY

not known

24D. LOCATION

Baltimore

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 17 1972

25B. NAME OF REGISTRAR

Andrew W. ...

25C. FUNERAL DIRECTOR

Phyllis C. ...

ADDRESS

6349 ...

20th April 1944

Dear Sir,
I have the pleasure to acknowledge the receipt of your letter of the 14th inst. in relation to the above matter.

I am sorry that I cannot give you a more definite answer at this time.

Very truly yours,

Yours faithfully,
J. H. ...

Enclosed for you are ...

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

REG. NO. 72 07844
STATE OF MARYLAND-DHMH

VS 150-REV. 1/1/68

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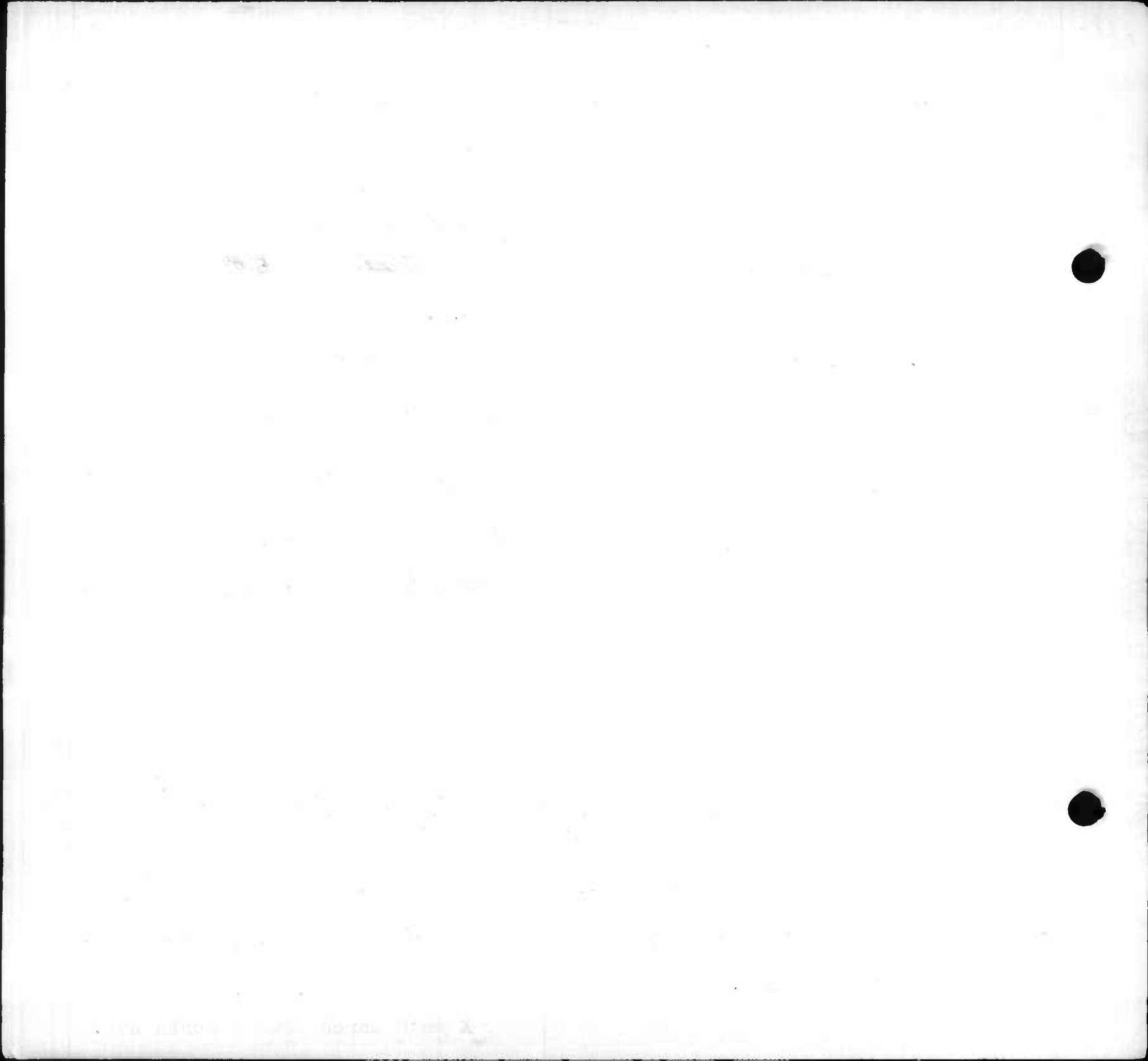
Handwritten text, possibly a signature or name, located in the upper right quadrant.

Handwritten text at the bottom left corner, possibly a date or reference number.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 07845		REG. NO. 72 07845	
CERTIFICATE OF DEATH					
STATE OF MARYLAND-DEMD					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>E. June Williams</i>		2. DATE AND HOUR OF DEATH <i>8/14/72 - 4:30 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Bolton Hill Nursing & Convalescent Center</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>909</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bolton Hill Nursing & Convalescent Center</i>		E. STREET AND NUMBER <i>1833 Aiken St.</i>			
5. SEX <i>MALE</i>	6. RACE <i>BLACK</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/15/22</i>	9. AGE (In years last birthday) <i>50</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>N.C.</i>	
13. FATHER'S NAME <i>B. Williams</i>		14. MOTHER'S MAIDEN NAME <i>Geneva Smith</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Admission Record</i>	
18. <i>41231</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Thrombosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
(B) <i>arteriosclerosis peripheral</i> DUE TO, OR AS A CONSEQUENCE OF: <i>yes</i>		(C) <i>arteriosclerosis generalized</i> <i>yes</i>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/21 1970</i> to <i>8/14 1972</i> that (I) (we) last saw the deceased alive on <i>8/17 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED <i>8/15/72</i>		23C. PHYSICIAN'S NAME (Type) <i>ALAN H MARCH MD</i>	
24A. BURIAL REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-18-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Auburn Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Balto., Md.</i>		24E. ADDRESS <i>2 E Reed St Balt Md 21202</i>		24F. DATE REC'D BY HEALTH DEPT. <i>AUG 17 1972</i>	
24G. NAME OF REGISTRAR <i>[Signature]</i>		24H. FUNERAL DIRECTOR <i>E Wm G March</i>		24I. ADDRESS <i>928 E North Ave.</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07846		BALTIMORE CITY HEALTH DEPARTMENT		72 07846	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO. STATE OF MARYLAND-DEMH	
1. NAME OF DECEASED (Type or Print) Ronald Joseph Macri RONALD MACRI		2. DATE AND HOUR OF DEATH 10:35 PM 8/15/72			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 10-3-72 Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Ohio B. COUNTY Belmont			
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		C. CITY OR TOWN MARTINS FERRY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 501 CONCORD ST.					
5. SEX MALE	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/7/48	9. AGE (In years last birthday) 24	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Wheeling, W. Va.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Hector J. Macri		14. MOTHER'S MAIDEN NAME MARTORIE Gautschi			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Martins Ferry, Ohio Heslop & Sons Funeral Home	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 746.21 INTRACEREBRAL HEMORRHAGE Antecedent Causes Consistent Cerebral Heart Disease (Tetralogy of Fallot) 2 shunts		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examination) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 7 19 72 to August 15 19 72 that (I) (we) last saw the deceased alive on August 15 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick L. Ferris III				23B. DATE SIGNED 8/15/72	
23C. PHYSICIAN'S NAME (Type) FREDERICK L. FERRIS III				23D. ADDRESS Johns Hopkins Hospital Baltimore Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Rem. Burial		24B. DATE 8-19-72		24C. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	
24D. LOCATION (City, town, or county) Martins Ferry, Ohio					
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972		25B. NAME OF REGISTRAR H. W. Jenkins		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.	
ADDRESS 1905 York Road Balto., Md. 2122					

10-3-1972 - Correction form from Funeral Director, Henry W. Jenkins & Sons Co. ;
Balto., Md. &

Letter from Heslop Funeral Home, Walnut at Fifth St., Martins Ferry, Ohio
per Edna Thiel, Secretary.

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

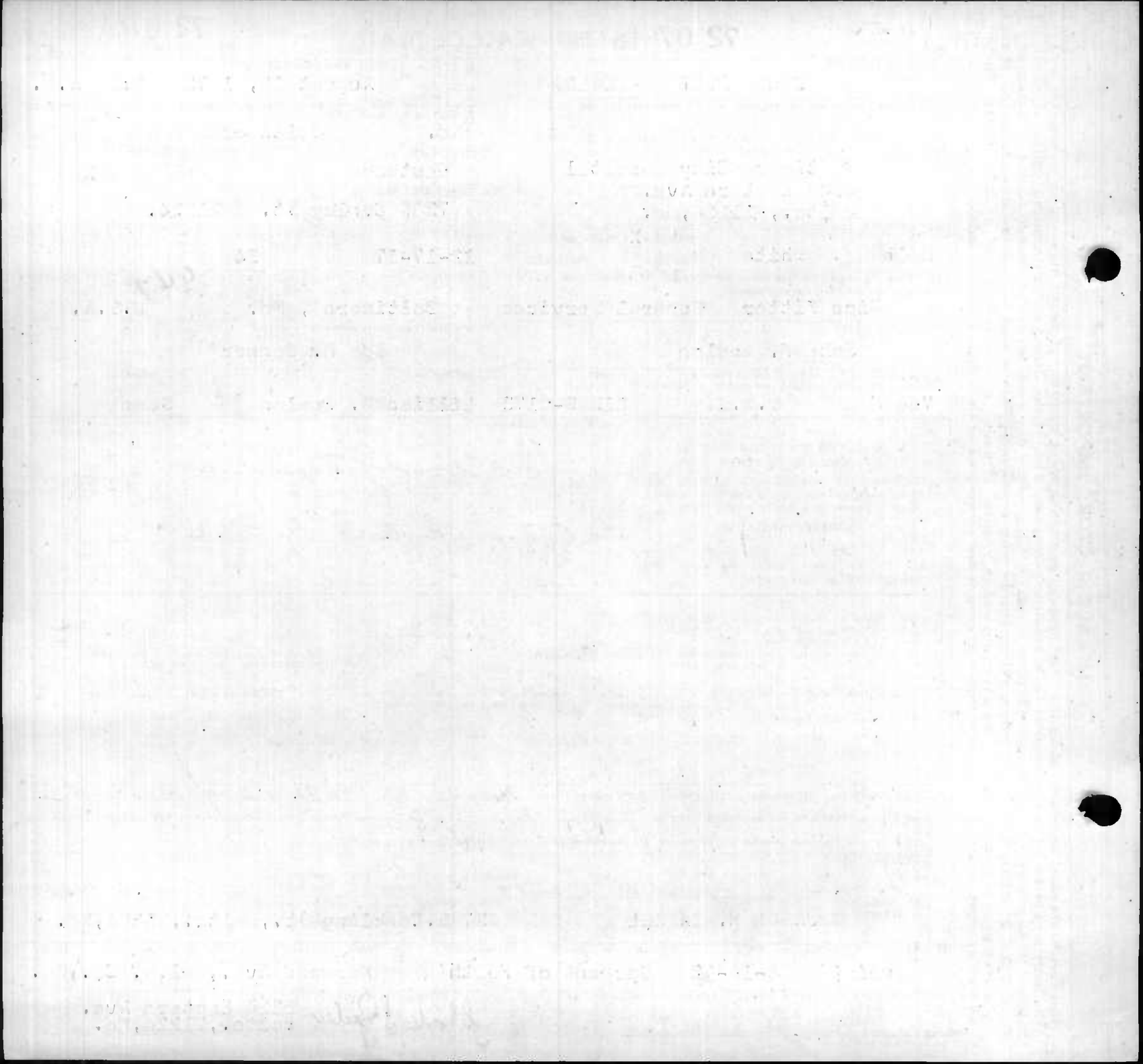
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07847
72 07847 CERTIFICATE OF DEATH				STATE OF MARYLAND-DMH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) KENNETH THOMAS MC CARTY		
2. DATE AND HOUR OF DEATH Aug. 16, 1972		10:35 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTO		
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 3100 Wyman Parkway		C. CITY OR TOWN Baltimore 21204		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER 1 C Fellowship Court				
5. SEX M	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/10/12	9. AGE (In years last birthday) 60
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY US Army		11. BIRTHPLACE (State or foreign country) NY
12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Joseph Mc Carty		14. MOTHER'S MAIDEN NAME Rose Mc Linden		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USA 1938-1960		16. SOCIAL SECURITY NO. 216-28-5443		17. INFORMANT Records- US PHS Hospital, Balto, Md.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of right lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Metastatic carcinoma left lung & adrenal Bullosus emphysema, left lung Esophagitis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Unknown Years Months				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Aug. 11 19 72 to Aug. 16 19 72 , that (I) (we) last saw the deceased alive on Aug. 16 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE MM Ruehsen M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/16/72
23C. PHYSICIAN'S NAME (Type) De Moraes Ruehsen, MD		23D. ADDRESS US PHS Hospital, Balto, Md. 21211		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/21/72		24C. NAME OF CEMETERY or CREMATORY Gettysburg National
24D. LOCATION (City, town, or county) (State) Gettysburg, Pennsylvania				
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972		25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR Wm. E. Johnson 8521 Loch Raven Bl.

Y

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

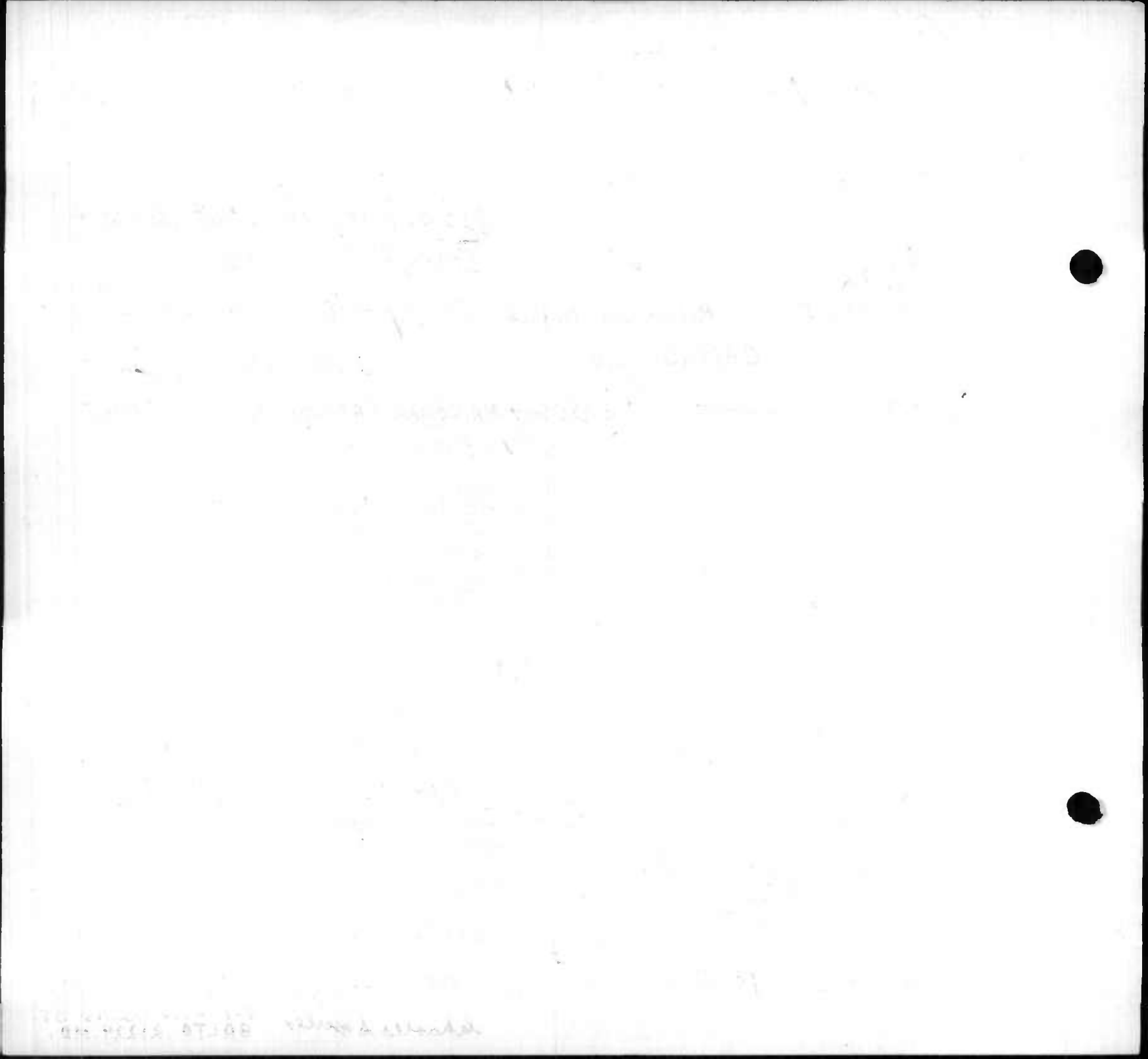
BALTIMORE CITY HEALTH DEPARTMENT									
72 07848 CERTIFICATE OF DEATH					REG. NO. 72 07848				
BIRTH NO. <u>N-450</u>					STATE OF MARYLAND - DHMH				
1. NAME OF DECEASED (Type or Print) <u>JOHN MILTON NEWLON</u>					2. DATE AND HOUR OF DEATH <u>August 15, 1972</u> <u>2:30 A.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>31 Baltimore City Hospital</u> <u>4940 Eastern Ave.</u> <u>Balto., 21224, Md.</u>					A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>				
					C. CITY OR TOWN <u>Eastwood</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
					E. STREET AND NUMBER <u>7305 Conley St. # 21224.</u>				
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-17</u>	9. AGE (In years last birthday) <u>54</u>	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Fitter</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>General Services</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John F. Newlon</u>					14. MOTHER'S MAIDEN NAME <u>Ida M. Benner</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W.II</u>			16. SOCIAL SECURITY NO. <u>21303-0173</u>		17. INFORMANT <u>Lillian M. Newlon</u>			ADDRESS <u>Same</u>	
18. <u>4-10-91</u> CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Coronary Thrombosis</u>					<u>7</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerosis C.V. Disease</u>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 29</u> 19 <u>71</u> to <u>August 15</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>July 17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>JASON H. GASKEL</u>					23B. DATE SIGNED <u>Aug. 16, 1972</u>				
23C. PHYSICIAN'S NAME (Type) <u>JASON H. GASKEL</u>					23D. ADDRESS <u>637 S. Conkling St., Balto., 21224, Md.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-18-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith</u>		24D. LOCATION (City, town, or county) (State) <u>Kenwood Ave., Balto. Co., Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 17 1972</u>		25B. NAME OF REGISTRAR <u>Andrew B. Keston</u>		25C. FUNERAL DIRECTOR <u>Shahady, S. Seiler</u>		ADDRESS <u>6224 Eastern Ave. Balto., 21224, Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07849
C-132 72 07849 CERTIFICATE OF DEATH				REG. NO. 72 07849
STATE OF MARYLAND				72 07849
BIRTH NO. C-132		1. NAME OF DECEASED (Type or Print) CAPPADOCCIO, Mr. ROMANO,		
2. DATE AND HOUR OF DEATH 8/15/72 2:15P.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hospital		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 100 North. Broadway St.		
4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD. B. COUNTY 2605		C. CITY OR TOWN city		
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 620 S. Rappolla Street 21224.		
5. SEX MALE	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE BIRTH PLACE Italy	9. AGE (in years last birthday) 92
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED.		10B. KIND OF BUSINESS OR INDUSTRY MODERN COAT MAKERS		11. BIRTHPLACE (State or foreign country) STATE of BIRTH
12. CITIZEN OF WHAT COUNTRY? AMERICAN.		13. FATHER'S NAME ? CAPPADOCCIO		
14. MOTHER'S MAIDEN NAME ? UNKNOWN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 216030664		17. INFORMANT MR. COSIMO CAPPADOCCIO		
ADDRESS SAME.		18. 2605 + 199.1		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) SEPTICEMIC SHOCK.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediately.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BILATERAL PNEUMONIA.		
		(B) DIABETES. MELLITUS.		
		(C) OCCULT CA.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 8/18/72 19__ to 8/15/72 19__ that (I) (we) last saw the deceased alive on 8/15/72 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Walker A. Impagliati		23B. DATE SIGNED 8/15/72.		23C. PHYSICIAN'S NAME (Type) WALKER, A. IMPAGLIATI
23D. ADDRESS Church Home & Hospital.		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 8-18-72		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER CEM.		24D. LOCATION (City, town, or county) (State) 4430 BELAIR RD., BALTO., MD.
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972		25B. NAME OF REGISTRAR Anthony...		25C. FUNERAL DIRECTOR Charles S. Seiler
ADDRESS 901 S. CONKLING ST. BALTO., 21224, MD.				



72 07850 CERTIFICATE OF DEATH

REG. NO. 72 07850
STATE OF MARYLAND - DEATH

BIRTH NO.		1. NAME OF DECEASED (Type or Print) STELLA BIALESKI-BIALECKI		2. DATE AND HOUR OF DEATH 16 AUG 72 - 10³⁰ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2636	
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 1887	9. AGE (In years last birthday) 85
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY HOUSE WORK		11. BIRTHPLACE (State or foreign country) POLAND	
13. FATHER'S NAME 2 CWIKLINSKI		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-16-5864		17. INFORMANT RECORDS 4940 Eastern Avenue Baltimore, Maryland 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH S.S. 219-16-5864 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF: (B) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF: (C) (Double Amputee)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4+ yrs 4+ years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from not 1970 19 to 16 Aug 19 72 that (I) (we) last saw the deceased alive on 16 Aug 72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edmund G. Beacham M.D.				23B. DATE SIGNED 16 Aug 72	
23C. PHYSICIAN'S NAME (Type) EDMUND G. BEACHAM M.D.				23D. ADDRESS Baltimore City Hospitals 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8-19-72		24C. NAME OF CEMETERY or CREMATORY SACRED HEART OF MARY CEM	
24D. LOCATION (City, town, or county) (State) 7601 GERMAN HILL RD. BA. CO., MD.		25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972			
25B. NAME OF REGISTRAR James J. Miller		25C. FUNERAL DIRECTOR Charles J. Miller 901 S. CONKLING ST. BALTO., 21224 MD.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

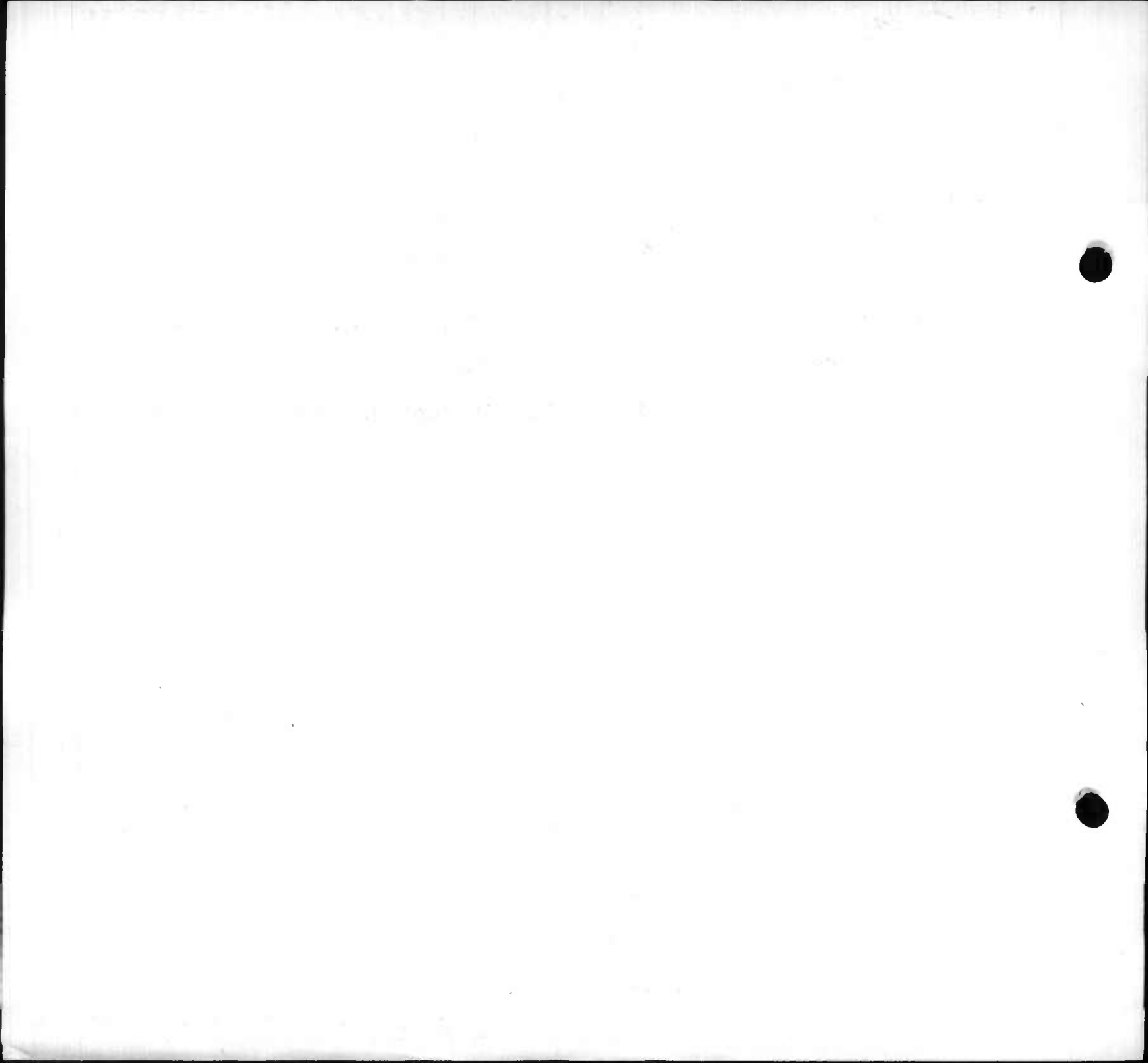
11/19/70

6314 Boston St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 07851		72 07851	
BIRTH NO.		8-536		72 07851	
1. NAME OF DECEASED (Type or Print)		LILLIAN SAUNDERLIN		2. DATE AND HOUR OF DEATH Aug 12 - 1972 3:55 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY		1606	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
LUTHERAN HOSPITAL 730 Ashburton St.		BALTIMORE		E. STREET AND NUMBER 607 ASHBURTON ST.	
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-27-1902	9. AGE (In years last birthday) 69	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME John Stanford	
14. MOTHER'S MAIDEN NAME Martha MNU		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-22-0216	
17. INFORMANT Mr. James Sauderlin		ADDRESS 607 Ashburton Street		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CARDIORESPIRATORY ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA - EMBOLISM? (B) DUE TO, OR AS A CONSEQUENCE OF: (C) SCVD, arterial fib. mixed CHA	
19. DATE OF OPERATION		19A. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) [Month] [Day] [Year] [Hour]		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 11 1972 to Aug 12 1972 that (I) (we) last saw the deceased alive on Aug 12 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ruben M. Marquez M.D.		23B. DATE SIGNED Aug 12, 1972		23C. PHYSICIAN'S NAME (Type) RUBEN MAURIQUEZ M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-17-72		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972		25B. NAME OF REGISTRAR Phillips	
25C. FUNERAL DIRECTOR Phillips		25D. ADDRESS 1727 N. Monroe St.		25E. ADDRESS Home	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07852

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Jessie M. Smith</i>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 8	Day 9	Year 72	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>46 Lutheran Hospital</i>		3. DATE PRONOUNCED DEAD		Month 8	Day 9	Year 72	Hour 5:00 a.m.
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>1606</i>		6. SEX <i>male</i>		7. RACE <i>Negro</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <i>9-28-14</i>		10. AGE (In years lost birthday) <i>57</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John Smith</i>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <i>Beatrice Taylor</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. <i>216-051862</i>		18. INFORMANT <i>Delores S. Pickett</i>		19. <i>412.4</i> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Arteriosclerotic cardiovascular disease		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20A. DATE OF OPERATION <i>2</i>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <i>yes</i>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <i>Peter Lipkovic</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>8/9/72</i>	
EXAMINER'S NAME (Type) <i>Peter Lipkovic, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/12/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 17 1972</i>		25B. NAME OF REGISTRAR <i>Aisley Whorston</i>		25C. FUNERAL DIRECTOR <i>Belington Phillips</i>		ADDRESS <i>1727 N. Main St.</i>	

James M. Smith
for the Rev. James Smith
of the Methodist Church

with reference to the same

James M. Smith
for the Rev. James Smith
of the Methodist Church

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07853		72 07853	
C-455				72 07853		72 07853	
BIRTH NO.				72 07853		72 07853	
BIRTH NO.				72 07853		72 07853	
1. NAME OF DECEASED (Type or Print) COLEMAN, John Charles				2. DATE AND HOUR OF DEATH 8-9-72 2:25 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1901			
5. SEX Male				6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4-3-26				9. AGE (In years last birthday) 46		10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME LAWRENCE W. COLEMAN				14. MOTHER'S MAIDEN NAME CATHERINE PHILLIP			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 9-13-44 to 2-12-47				16. SOCIAL SECURITY NO. 218-18-5881		17. INFORMANT VA Hospital Records ADDRESS Baltimore, Maryland 21218	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) APPARENT CARDIORESPIRATORY FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ? HYPERKALEMIA URINARY OUTPUT				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7/27/72 - 8/8/72			
19. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION NONE 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) NONE				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) NONE			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that XII (this hospital) attended the deceased from July 26, 1972 to August 9, 1972 , that II (we) lost saw the deceased alive on August 9, 1972 and that in our (our) opinion death occurred on the date and hour and from the causes stated above, XII (We) (did) not view the body after death.							
23A. SIGNATURE Thomas E. Murphy, Jr. M.D. DEGREE MD				23B. DATE SIGNED 8-9-72		23C. PHYSICIAN'S NAME (Type) THOMAS E. MURPHY, JR. M. D. DEGREE MD	
23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8/14/72		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) B.A. Co. (State) Md.							
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972				25B. NAME OF REGISTRAR Sidney W. Gordon		25C. FUNERAL DIRECTOR Wilmington B. Phillips ADDRESS 1727 N. Mount St.	

213

[illegible]

7-1-12 5-1-12 05-1-12

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07854

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print)		MILDRED WILLIAMS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year August 11, 1972		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD		Month Day Year August 11, 1972		Hour 7:35 P. M.	
CERTIFICATE AMENDED Maryland General Hospital (DOA)				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland		B. COUNTY 1703	
6. SEX Female		7. RACE White Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 1929 July 7, 1928		10. AGE (in years last birthday) 44 43		11. BIRTHPLACE (State or foreign country) North Carolina Virginia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Benson	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Daisy Hyman					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 229-30-3212		18. INFORMANT Mr. George Williams		ADDRESS 609 Whitelock Street			
MEDICAL CERTIFICATION		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(A) IMMEDIATE CAUSE Stabwound of chest DUE TO, OR AS A CONSEQUENCE OF:							
		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:							
		(C) _____							
20A. DATE OF OPERATION 8-11-72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED						21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) front steps		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 634 W. Lanvale Street		1703			
22D. TIME OF INJURY (APPROX.) 8-11-72 7:00		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Stabbed during altercation					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Marvin S. Platt</i> M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 12, 1972									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-17-72		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972		25B. NAME OF REGISTRAR <i>Lidney</i>		25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 N. Monroe St.			

9-25-1972 - Correction form from Funeral Director, Arlington S. Phillips, Balto., Md.
and Birth Certificate of deceased, Registration District No. 25-2180,
North Carolina State Board of Health, Certificate No. 152, filed 7-19-29

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 07855		REG. NO. 72 07855	
S-536		72 07855		STATE OF MARYLAND-DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SANDERS GEORGE		8 - 12 - 1972 6:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Washington, D. C.		V4-8	
SINAI HOSPITAL OF BALTIMORE INC.		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER		1535 Kearny Street, N. E.	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
m	N		March 2, 1896	76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Jacob Sanders		Cecily Rome		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		220-14-1219A		Mrs. Minnie Sanders 1535 Kearny St, N.E.	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Acute Myocardial Infarction 3 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		Complete Heart block	
		(C) DUE TO, OR AS A CONSEQUENCE OF:		Possible occult malignancy.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 8 - 2 - 1972 to 8 - 12 - 1972 that (H) (we) last saw the deceased alive on 8 - 12 - 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
P. PRASAD MB					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
P. PRASAD MB		SINAI HOSPITAL, Belvedere Ave, Balto Md 21201			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8-16-72		Arbutus Mem. Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 17 1972		Sidney [Signature]		Arlington St Phillips 1727 N. Monroe Street	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07856	
72 07856				STATE OF MARYLAND-DHMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DRAVER, LOUIS		AUGUST 15, 1972 12.00 NOON M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE B. COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			MARYLAND BALTIMORE		
ST. AGNES HOSPITAL CATON & WILKENS AVES BALTIMORE, MARYLAND 21229			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
40			BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER			1324 NO ROLLING RD 21228		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days
MALE	CAUCASIAN	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	06/13/90	82	Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
BAKER		HOTEL		MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
HENRY DRAVER			MARY BETZOLD DRAVER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
W W 1		216-12-7154		ST. AGNES HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Approximate interval between onset and death		
ANTECEDENT CAUSES			A. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Arythmia		
II			Acute anteroseptal MI 4 d.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			Diabetes mellitus		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NONE	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work			
22. I certify that (I) (this hospital) attended the deceased from AUGUST 11 1972 to AUGUST 15 1972, that (I) (we) last saw the deceased alive on AUGUST 15 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
DR APTER				8-15-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				BALTIMORE, MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE	
Burial				8/19/72	
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
Crestlawn				Ellicott City, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 17 1972		Audrey Johnston		Witzke, 1630 Edmondson Avenue 21228	

1520 1521

B-500

72 07857 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07857

BIRTH NO.

STATE OF MARYLAND-DEME

1. NAME OF DECEASED (Type or Print) OTTIS H. BOWEN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> AUG M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour August 15, 1972 1:50 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 11/30/09		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 62		E. STREET AND NUMBER 515 Brunswick Street	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur Bowen		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
15. MOTHER'S MAIDEN NAME Lucy Clifton		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 216-09-1006		18. INFORMANT ADDRESS Mrs. Mary Ellen O'Neill 4814 Knoll Glen Drive 21043	
19. 571.81 + 4887X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Fracture femur			
20A. DATE OF OPERATION 8/18/72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 8/15/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/72	
24C. NAME of CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 17 1972		25B. NAME OF REGISTRAR Sidney Witzke	
25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue 21228		ADDRESS	

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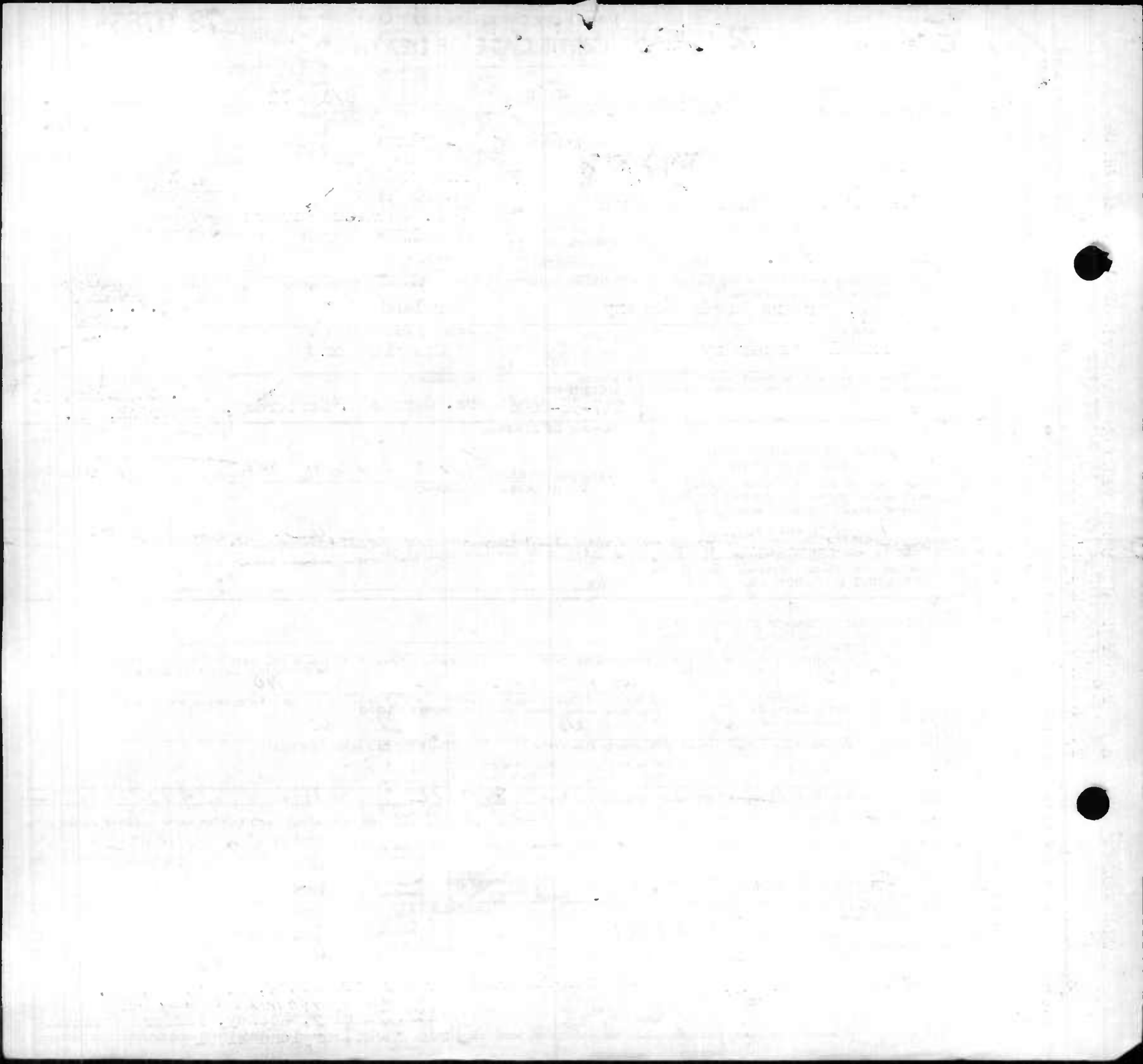
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FUNERAL DIRECTOR: IMPORTANT
THE MEDICAL EXAMINER'S OFFICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-236		72 07858		BALTIMORE CITY HEALTH DEPARTMENT		72 07858	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
EASTERDAY, William Lewis				8/14/72 11:59 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
The Johns Hopkins Hospital				Maryland Frederick			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Frederick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				7 S. Market Street			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
Male	Cauc.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8/12/50	22	Employee, Farmers Supply Company		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?				
Maryland			U.S.A.				
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
Daniel Easterday			Carrie Kemp				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS	
No			217-56-0606			Mrs. Carrie K. Easterday, 7 South Market St Frederick, Md.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				TUMOR OF PINOC REGION.			
ANTECEDENT CAUSES				(B) HEMORRHOGE INTO TUMOR.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) Stating the UNDERLYING CONDITION last				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II				NONE.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
8/7/72		HYDROCEPHALUS 2° TO TUMOR		YES		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
NO		NO		NO			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
NO		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		NO			
22. I certify that (I) (the hospital) attended the deceased from 8/7/72 19 72 to 8/14/72 19 72							
that (I) (we) lost saw the deceased alive on 8/14/72 19 72 and that in (my) (our) opinion death occurred on the date							
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 11 59 AM 8/14/72							
23A. SIGNATURE				23B. DATE SIGNED			
Bruce E. Northrup				8/14/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
BRUCE E. NORTHRUP.				601 N. BROADWAY, BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Aug 17, 1972		Resthaven Memorial Gardens		Frederick, Frederick, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
AUG 18 1972		[Signature]		Smith, Fadelay, Keeney, Basford Funeral Frederick, Maryland 21701			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07859

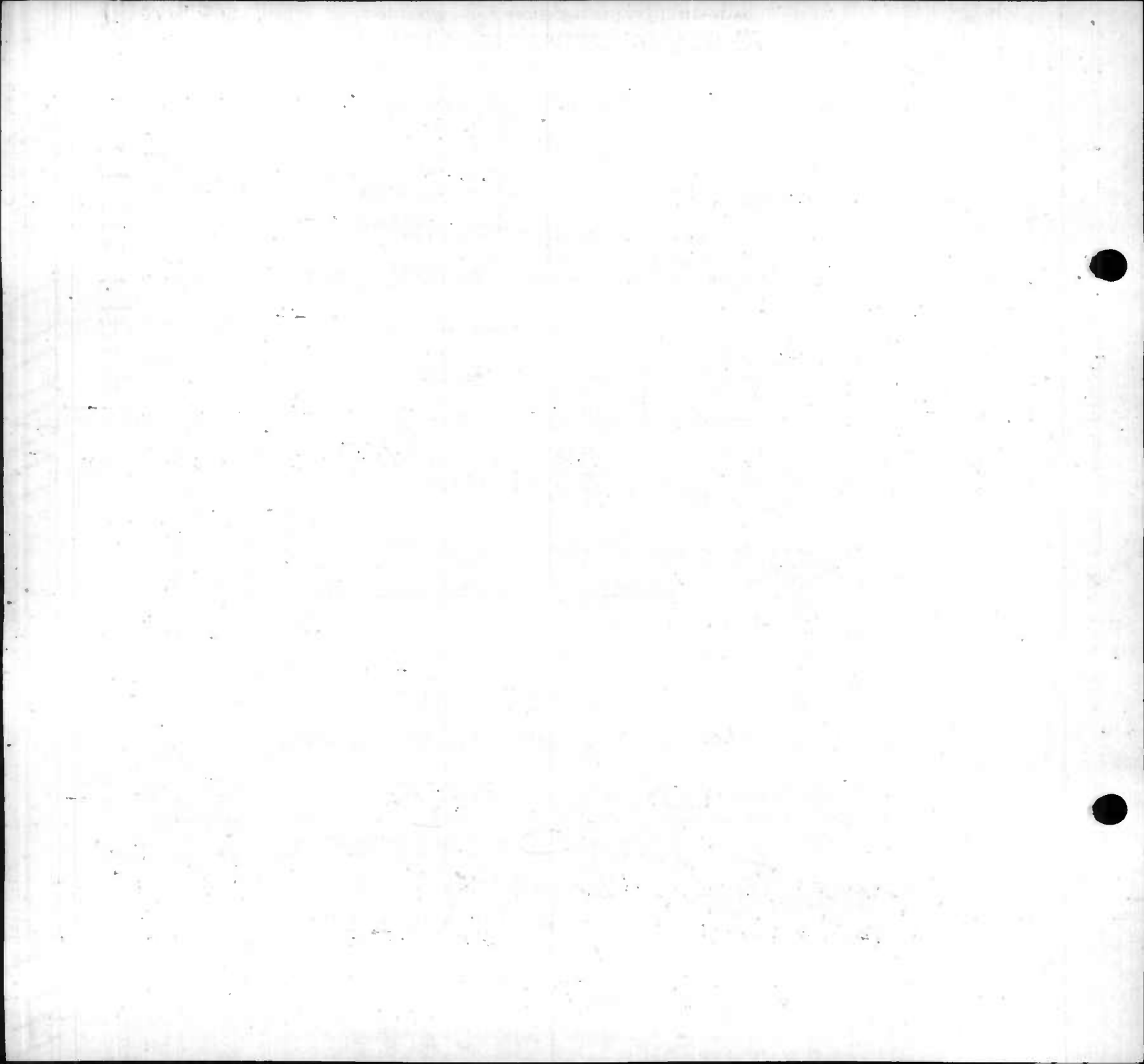
BIRTH NO.

1. NAME OF DECEASED (Type or Print) THOMAS ROSE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 17, 1972		M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2544 W. Baltimore Street		3. DATE PRONOUNCED DEAD Month Day Year Hour August 17, 1972 1:49 A.M.		
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2002				
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 12-3-1914		10. AGE (In years, last birthday) 58	11. BIRTHPLACE (State or foreign country) S.C.	
12. CITIZEN OF WHAT COUNTRY U.S.		13. FATHER'S NAME John Rose		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		
15. MOTHER'S MAIDEN NAME				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY No.		18. INFORMANT ADDRESS
19. 151.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Metastatic adenocarcinoma of stomach ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 17, 1972				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-21-72	24C. NAME OF CEMETERY or CREMATORY Arbutus	24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972	25B. NAME OF REGISTRAR Sidney S. Houston	25C. FUNERAL DIRECTOR ADDRESS C. W. ... 2700 Edmondson Ave.		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07860
72 07860				REG. NO.
BIRTH NO.				STATE OF MARYLAND - D.H.M.H.
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH	
WINNIE DONALDSON			August 13, 1972 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY	
00 1528 Presser Court			MARYLAND	
			C. CITY OR TOWN	
			BALTIMORE	
			D. INSIDE CITY LIMITS?	
			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
			E. STREET AND NUMBER	
			1528 Presser Court	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Female	BLACK	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4/9/1910	62
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife		Home		Morven, North Carolina
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?	
FRANK TEAL			U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	
No.			213-26-3494	
17. INFORMANT			ADDRESS	
Mr. Oliver Donaldson			1528 Presser Court	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			Generalized arteriosclerosis	
ANTECEDENT CAUSES			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			5 yrs	
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
0 none				NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 8-3-72 19 to 8-15-72, that (I) (we) lost saw the deceased alive on 8-11-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
Dean R. Taylor M.D.				8-17-72
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
Dr. DEAN R. TAYLOR		MD Johns Hopkins Hospital 513 Carnegie		
		601 N. BROADWAY Baltimore, MD 21205		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)
Burial	8/17/72	Arbutus Memorial Park		Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS		
AUG 18 1972	Andrew...	MORTON & DYETT F.H. 1701 Laurens Street		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07861

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES PARROTT (ROBERT)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CITY HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour M. August 15, 1972 9:40 A.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2037	
9. DATE OF BIRTH OCT 18, 1916		10. AGE (In years lost birthday) 56 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) CHESTER COUNTY, S. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE PARROTT		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEVEDORE	
15. MOTHER'S MAIDEN NAME MAMIE HINTON		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 213-07-0054		18. INFORMANT ADDRESS MRS. MAMIE H. JOHNSON 2318 BRYANT AVENUE	
19. 412.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. DATE SIGNED 8/15/72 EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-21-72	
24C. NAME of CEMETERY or CREMATORY CEDAR HILL CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972		25B. NAME OF REGISTRAR A. J. Johnson	
25C. FUNERAL DIRECTOR MORTON & DYETT FUNERAL HOME 1701 ALAURENS		ADDRESS	

(100-1)

X

OCT 11, 1918

DEWEE STREET

WESTERN COUNTY, N. Y.

WATER STREET

STEVENS

21-07-0020 MRS. W. E. JOHNSON 231 W. 1ST AVENUE

STEVENS, W. E. JOHNSON, 231 W. 1ST AVENUE

WILLIAM, WYLAND

• 21-07-0020

-11-11

UNIT 1

WYLAND, WYLAND, 231 W. 1ST AVENUE

FUNERAL DIRECTOR: IMPORTANT

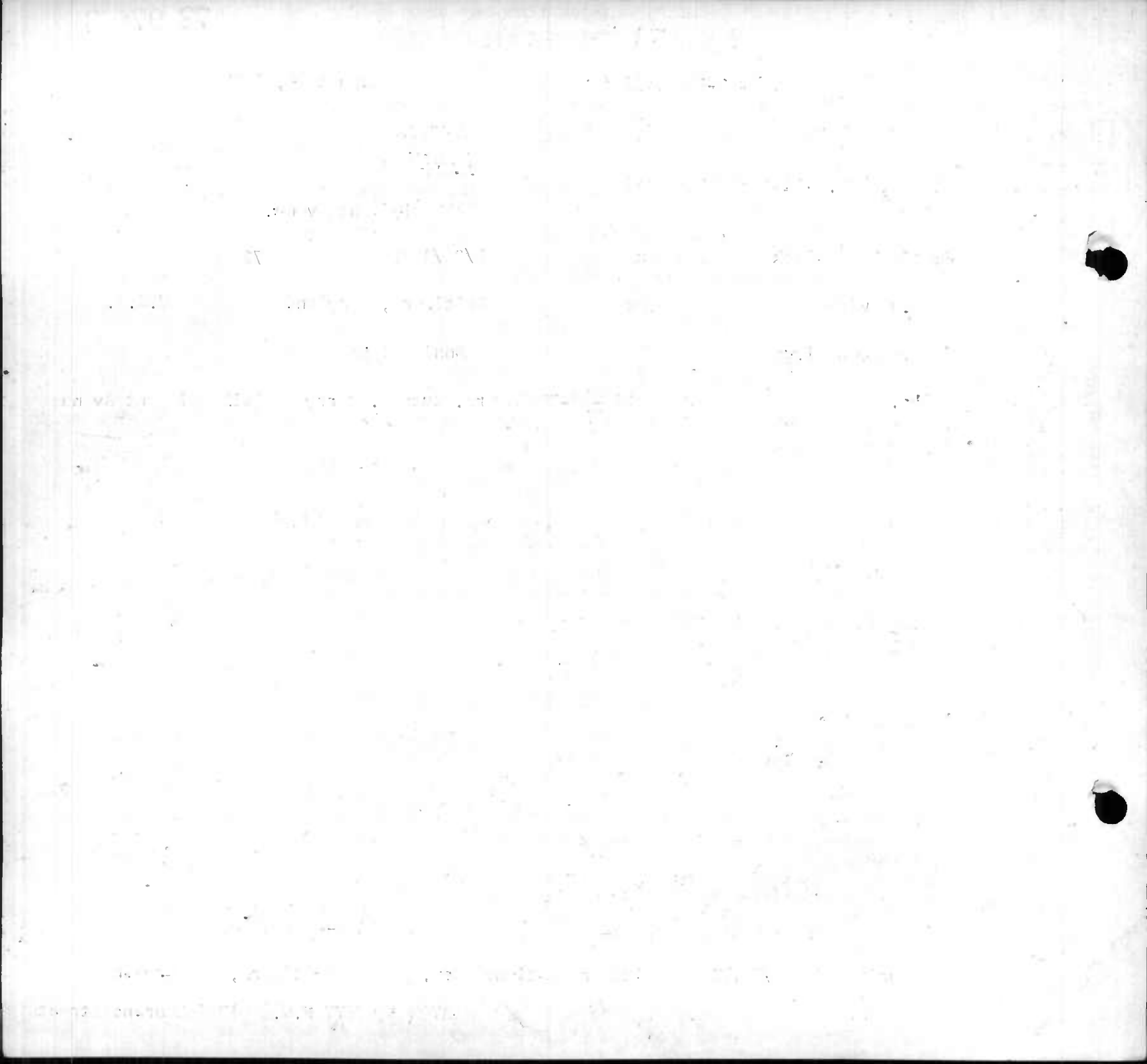
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07862		72 07862	
R-152				72 07862		72 07862	
BALTIMORE CITY HEALTH DEPARTMENT				72 07862		72 07862	
BALTIMORE CITY HEALTH DEPARTMENT				72 07862		72 07862	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Frank Robinson				8-15-72 4:55 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL				A. STATE Md. B. COUNTY			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore			
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 1600 Holbrook Ave.			
5. SEX M	6. RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/21/1919	9. AGE (In years last birthday) 53	10. UNDER 1 Yr. Months: Days	11. UNDER 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lancaster, S. C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Adolphus Robinson				14. MOTHER'S MAIDEN NAME Janie Ellison			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 249 10 4327		17. INFORMANT Berlina Graham	
				ADDRESS SAME			
18. 560.91 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE: ANOXIA 2° to ASPIRATION DUE TO, OR AS A CONSEQUENCE OF: (B) SMALL BOWEL OBSTRUCTION DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bowel Obstruction		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-2 1972 to 8-15 1972 that (I) (we) last saw the deceased alive on 8-15 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Thomas V. Whitten M.D.				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) Thomas V. Whitten, M.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/18/72		24C. NAME of CEMETERY or CREMATORY Clinton Cemetery		24D. LOCATION (City, town, or county) (State) Lancaster, S. C.	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972		25B. NAME OF REGISTRAR Sidney Johnston		25C. FUNERAL DIRECTOR MORTON & DYETT FUNERAL HOME, 1701 Laurens St. Baltimore, Maryland		25D. ADDRESS 21217	

7/13/72 { operation
7/10/72 }

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-200		72 07863		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07863	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND-DEME	
		ROSA MAZIE MACKEY		August 14, 1972		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 MT. SINAI NURSING HOME				A. STATE MARYLAND B. COUNTY			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3412 Piedmont Avenue			
5. SEX Female	6. RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/26/1900	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Diggs				14. MOTHER'S MAIDEN NAME Annie Diggs			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 214-01-7343A		17. INFORMANT ADDRESS Mrs. Ruth M. Perry 3412 Piedmont Avenue			
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc., it means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Heart failure (B) Hypertensive Ar. C.V.D. DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days Years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 6, 1972 to Aug 14, 1972, that (I) (we) last saw the deceased alive on Aug 14, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Kennard Yaffe M.D.				23B. DATE SIGNED 8/15/72			
23C. PHYSICIAN'S NAME (Type) KENNARD YAFFE M.D.				23D. ADDRESS 5501 Forest Park Ave			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/72		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972		25B. NAME OF REGISTRAR D. J. Wharton		25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens Street	



1

BC-Montgomery Co. 72 07864

D-620

STATE OF MARYLAND
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 72 07864

1. NAME OF DECEASED (Type or Print) EDWARD DRAKE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) So. Balto. Gen. Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year 8 14 1972	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Prince George	
9. DATE OF BIRTH Nov. 27, 1971		10. AGE (In years last birthday) 9	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wayne G. Drake		14. MOTHER'S MAIDEN NAME Shelby Henson	
15. STREET AND NUMBER 11668 Pumpkin Hill Dr. #5142		16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
17. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		18. KIND OF BUSINESS OR INDUSTRY None	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		20. SOCIAL SECURITY NO. -----	
21. INFORMANT Wayne G. Drake		22. ADDRESS Same as Above	
19. 484X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Dehydration		CAUSE OF DEATH Acute Interstitial Pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Day 1 - 2 Days	
20A. DATE OF OPERATION 2 Dec. 1971		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Absence of colon, Ileostomy	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
<p>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/></p> <p>DATE SIGNED 8-14-72</p> <p>ACTUAL SIGNATURE Marvin S. Platt M.D.</p> <p>EXAMINER'S NAME (Type) Marvin S. Platt, M.D.</p>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		8-16-72	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Ft. Lincoln Cemetery		Colmar Manor, P. G. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
AUG 18 1972		Sidney Johnson	
25C. FUNERAL DIRECTOR		25D. ADDRESS	
F. Gasch's Sons 4739 Balt. Ave. Hyatts. Md.			

VS 151-REV. 1/1/68

1 7 2 0 0 0 3 8 6 0

8-24-1972 - Completion of cause of death on a pending medical examiner death certificate,
Marvin S. Platt, M.D. HRS

FUNERAL DIRECTOR: IMPORTANT

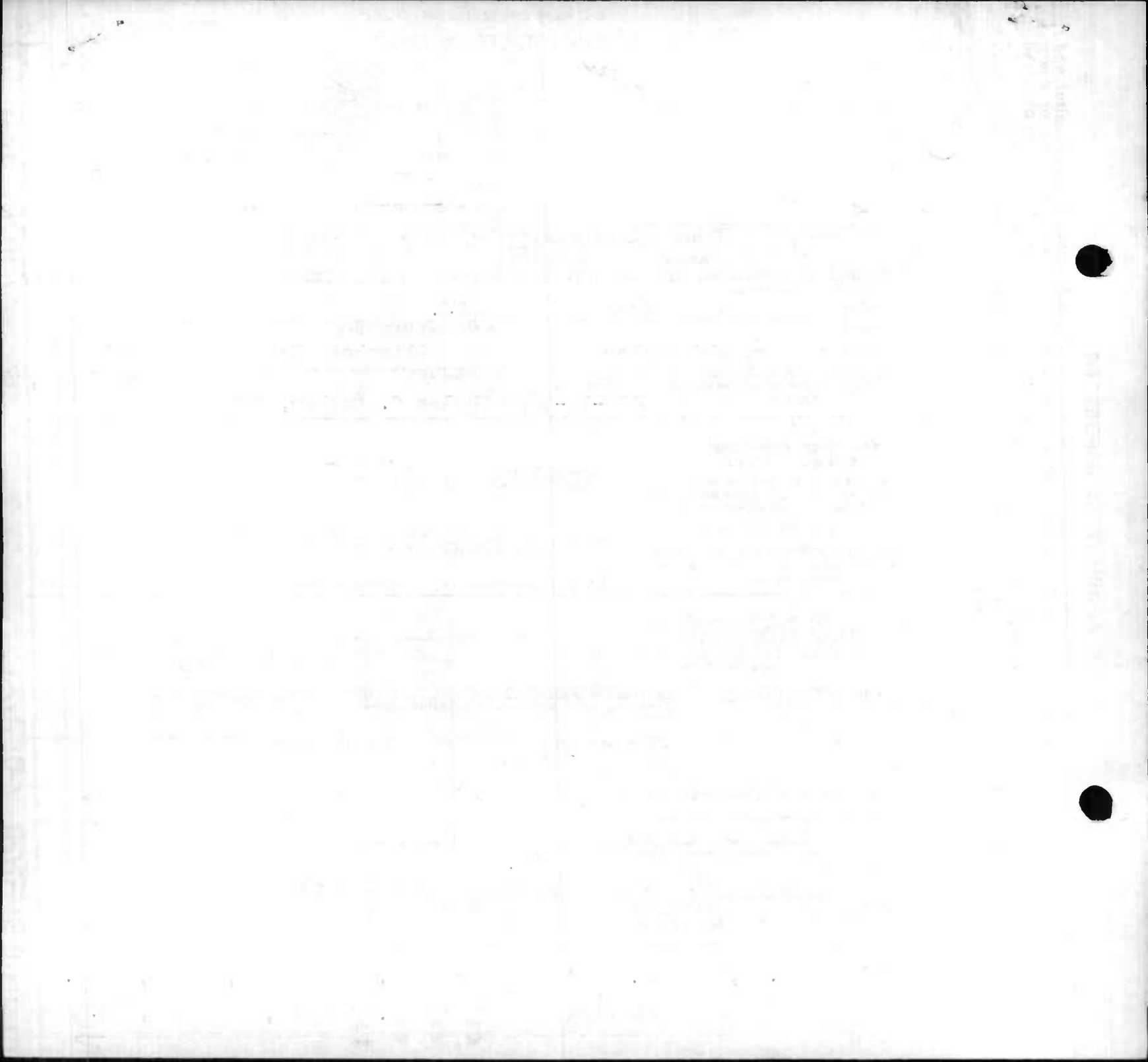
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-460		72 07865		BALTIMORE CITY HEALTH DEPARTMENT		72 07865	
BIRTH NO.		72 07865		CERTIFICATE OF DEATH		REG. NO. 72 07865	
1. NAME OF DECEASED (Type or Print) TAYLOR, ANDREW B.				2. DATE AND HOUR OF DEATH August 14, 1972 2:30 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 23 Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY HARFORD C. CITY OR TOWN BEL AIR, MARYLAND D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Rt 1, Box 413			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/22/23	9. AGE (In years lost birthday) 49	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY Trucking Business		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jaziel H. Taylor (Greenwood)				14. MOTHER'S MAIDEN NAME Ennice Mabe (Greenwood)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 220 14 8554		17. INFORMANT ADDRESS CLIN RCDS, VAH, BALTIMORE, MARYLAND 21218			
18. 519.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CHRONIC OBSTRUCTIVE LUNG DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. RHEUMATOID ARTHRITIS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 24, 19 72 to August 14, 19 72 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 14, 19 72 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) EXAMINE view the body after death.							
23A. SIGNATURE x Barry Z. Izenstein MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/14/72	
23C. PHYSICIAN'S NAME (Type) BARRY Z. IZENSTEIN, M.D.				23D. ADDRESS VA HOSPITAL, BALTIMORE, MARYLAND 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/1972		24C. NAME OF CEMETERY or CREMATORY Bell Air Memorial Gds		24D. LOCATION (City, town, or county) (State) Aberdeen, Harford Co Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972		25B. NAME OF REGISTRAR Andrew Taylor		25C. FUNERAL DIRECTOR ADDRESS TARRINGS FUNERAL HOME ABERDEEN, MARYLAND Walter Greenwald Sr.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07866	
B-246 BIRTH NO.		72 07866		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>HOWARD Walter BUSLER</u>		2. DATE AND HOUR OF DEATH <u>8/16/72</u> <u>11⁵⁰ P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Harford</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MD. GENERAL HOSPITAL</u> <u>48</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Joppa, MD</u>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>3/16/19</u>		9. AGE (In years last birthday) <u>53</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joshua Garfield Busler</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Helen Winskowski</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>215-18-3670</u>	
17. INFORMANT <u>Thelma C. Busler, 2310 Cheyenne Ave</u>		ADDRESS <u>Joppa, Md</u>		18. <u>203X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>UREMIA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>MULTIPLE MYELOMA</u>	
19. DATE OF OPERATION <u>0</u>		20. AUTOPSY? (Yes or No) <u>NO</u>		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that (1) (this hospital) attended the deceased from <u>7/27/72</u> to <u>8/16/72</u> and that (2) (we) last saw the deceased alive on <u>8/16/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (Yes) (did) (did not) view the body after death.		23. SIGNATURE <u>Wayne W. W. MD</u> <u>W. W. W. MD</u>		24. DATE SIGNED <u>8/17/72</u>	
25. DATE REC'D BY HEALTH DEPT. <u>AUG 18 1972</u>		26. NAME OF REGISTRAR <u>Howard K. McComas</u>		27. FUNERAL DIRECTOR <u>Howard K. McComas, Abingdon, Md.</u>	



72 07867

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07867

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Fenton R. Fadeley /FENTON/FADLEY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 12 1972 10:46p M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel		C. CITY OR TOWN Annapolis D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Mar 16 1949	10. AGE (In years lost birthday) 23	11. BIRTHPLACE (State or foreign country) Washington D. C.	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Richard W. Fadeley	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		14B. KIND OF BUSINESS OR INDUSTRY None	
15. MOTHER'S MAIDEN NAME Anne Leeke		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Richard W. Fadeley ADDRESS 3 Edge Hill Annapolis Md. 21405	
19. E 812.0 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cranio-cerebral injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 21		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) road	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Old Solomon Rd. & West St. - Annapolis		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 8-12-72 8:30 p.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Driver in auto-auto accident.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. Deputy Chief Medical Examiner ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-14-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE Aug 16 1972	
24C. NAME of CEMETERY or CREMATORY Fort Lincoln Crem.		24D. LOCATION (City, town, or county) (State) Pri George Co. Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972		25B. NAME OF REGISTRAR Sidney W. Norton	
25C. FUNERAL DIRECTOR John M. Taylor & Sons		25D. ADDRESS Annapolis, Md.	

X

also white

Mar 10 1940

Washington D. C.

Dear Sirs

Yr

Enclosed are 10 copies of

copy

8-13-40

Respectfully,
R. B. [Signature]

Enclosure and 10 copies of [illegible]

John W. [illegible]

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				72 07868		REG. NO.		72 07868							
BIRTH NO.				CERTIFICATE OF DEATH											
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH											
Summers, Phoebe				8-11-72 1:30 P.M.											
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)											
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY		C. CITY OR TOWN		D. INSIDE CITY LIMITS?					
Harbor View Nursing Home				MD		BALTO		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2403					
E. STREET AND NUMBER				113 E. Hamburg ST.											
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. If Under 1 Yr. Months Days		11. If Under 24 Hrs. Hours Min.			
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4/28/00		72							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Unknown				Unknown				Unknown				Unknown			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)							
Unknown				Unknown				Unknown							
16. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS							
Unknown				Unknown				Harbor View Nursing Home							
18. CAUSE OF DEATH				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
I				(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				10/71			
ANTECEDENT CAUSES				DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:				years			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:				years			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0															
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?							
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>											
22. I certify that (I) (this hospital) attended the deceased from 10/22 1971 to 8/11 1972 that (I) (we) last saw the deceased alive on 8/11 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE												23B. DATE SIGNED			
[Signature]												8/12/72			
23C. PHYSICIAN'S NAME (Type)												23D. ADDRESS			
ALAN H MACARTHY MD												2 E Red St Baltimore 21202			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Burial				8/15/72				Glen Haven Mem. Pk				Glen Burnie, Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR				ADDRESS			
AUG 18 1972				Lisney Thornton				George J. Gance				4001 R. Ichie Hwy Baltimore Md 21225			

10/11

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Highland C & S
Carter's General

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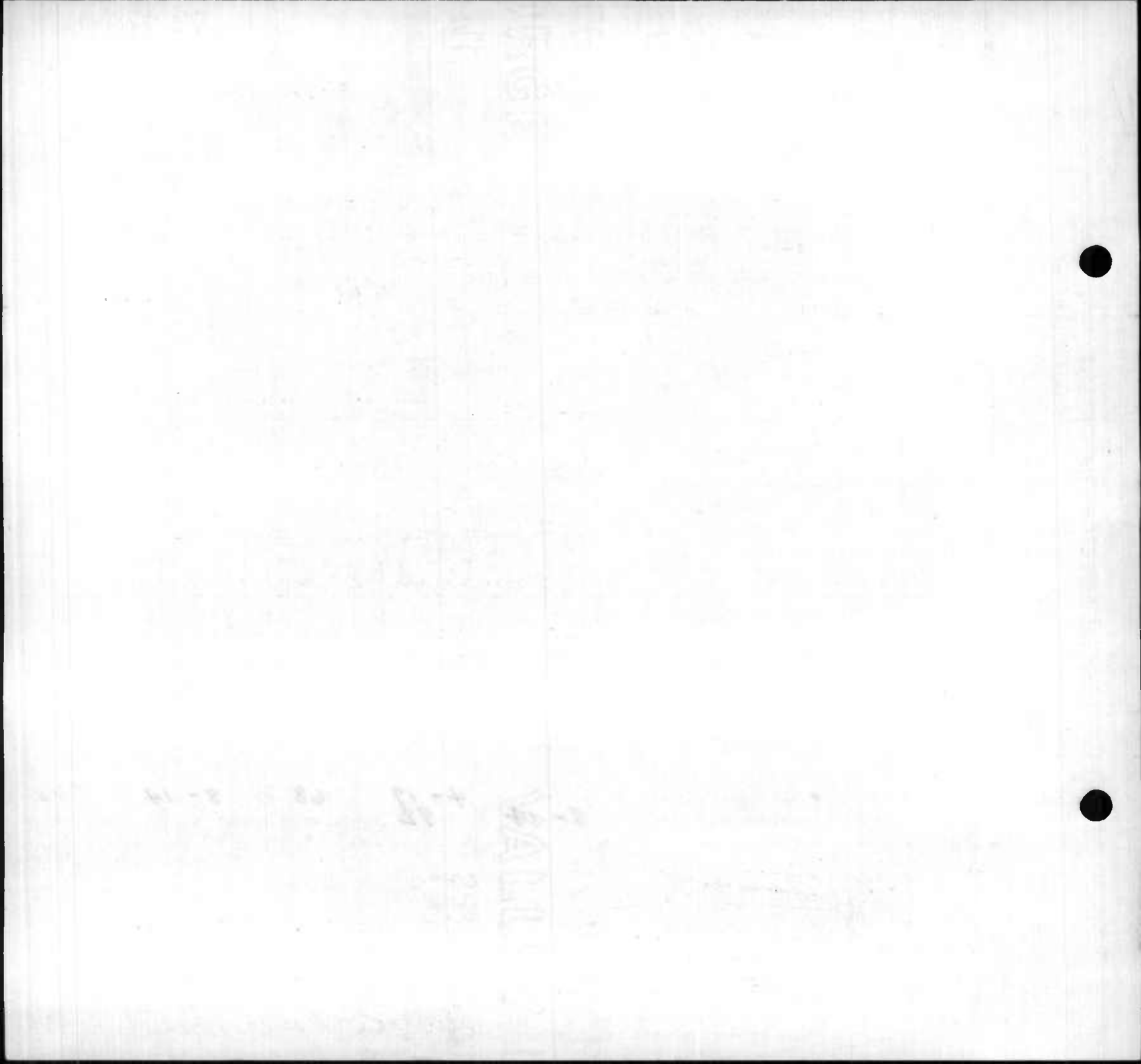
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FUNERAL DIRECTOR: IMPORTANT

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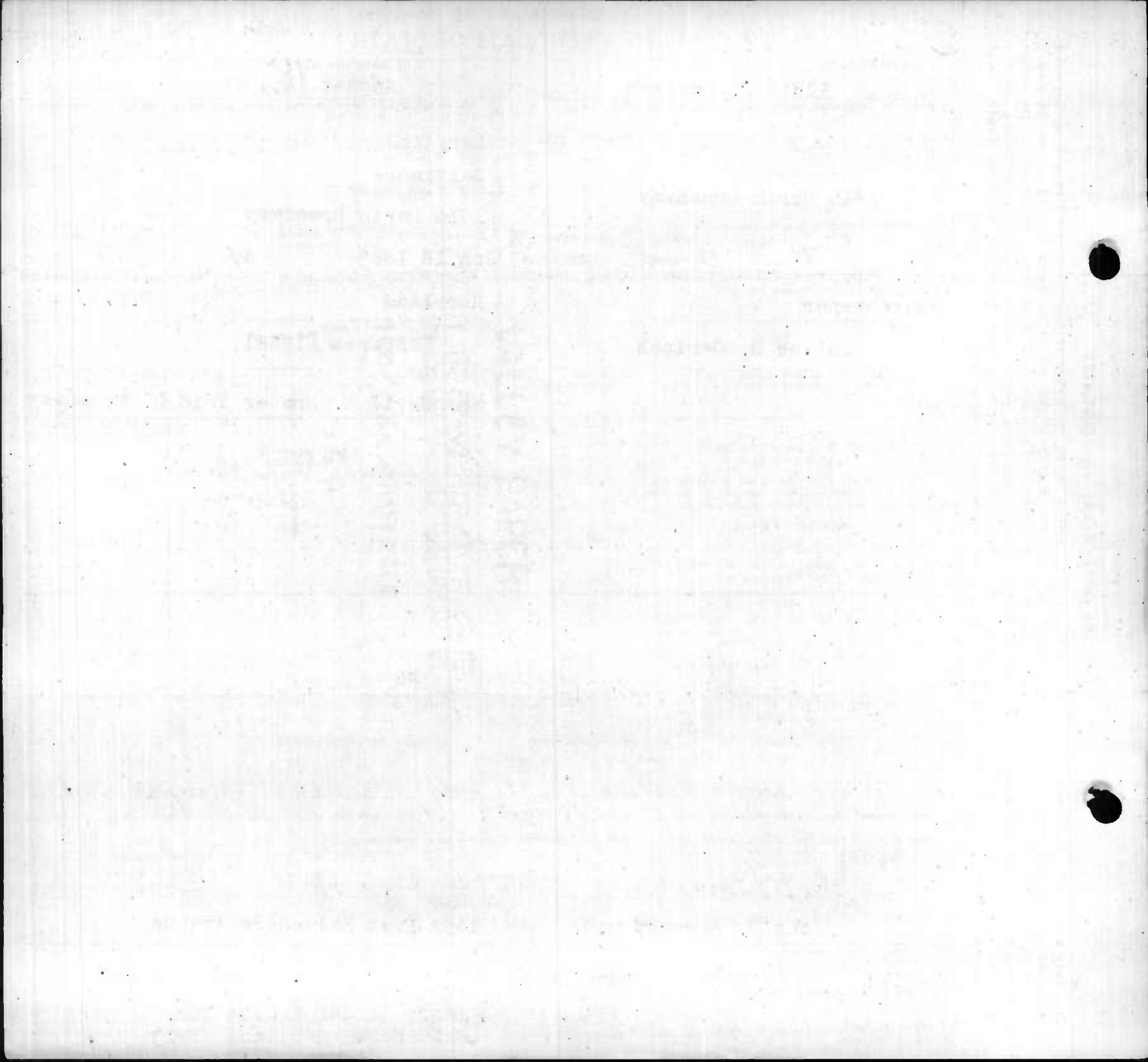
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07869	
C-245 72 07869				STATE OF MARYLAND-DEPT.	
1. NAME OF DECEASED (Type or Print) Sister Stella Coughlin			2. DATE AND HOUR OF DEATH 8-14-72 7 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SETON PSYCHIATRIC INSTITUTE			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2841 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4000 Forest Hill Rd.		
5. SEX F	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-14-79	9. AGE (In years last birthday) 93	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious		10B. KIND OF BUSINESS OR INDUSTRY Receptionist		11. BIRTHPLACE (State or foreign country) Boston Mass.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John Coughlin		
14. MOTHER'S MAIDEN NAME Mary Mahoney			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 220-46-0837- J1			17. INFORMANT ADDRESS Erma K. Cox R.N. Seton Institute		
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Dysrhythmia. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic heart disease (B) DUE TO, OR AS A CONSEQUENCE OF: Generalized Atherosclerosis (C) Cerebrovascular accident			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-19 1968 to 8-14 1972 , that (I) (we) last saw the deceased alive on 8-14 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edmundo Larranaga M.D.				23B. DATE SIGNED 8-14-72	
23C. PHYSICIAN'S NAME (Type) Edmundo Larranaga M.D.				23D. ADDRESS 6400 Wabash Ave. Baltimore Md. 21215	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 8/15/72		24C. NAME OF CEMETERY OR CREMATORY St. Joseph	
24D. LOCATION (City, town, or county) (State) Emmitsburg Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972			
25B. NAME OF REGISTRAR Glenn E. Wilson		25C. FUNERAL DIRECTOR ADDRESS Emmitsburg, Md.			



FUNERAL DIRECTOR: IMPORTANT

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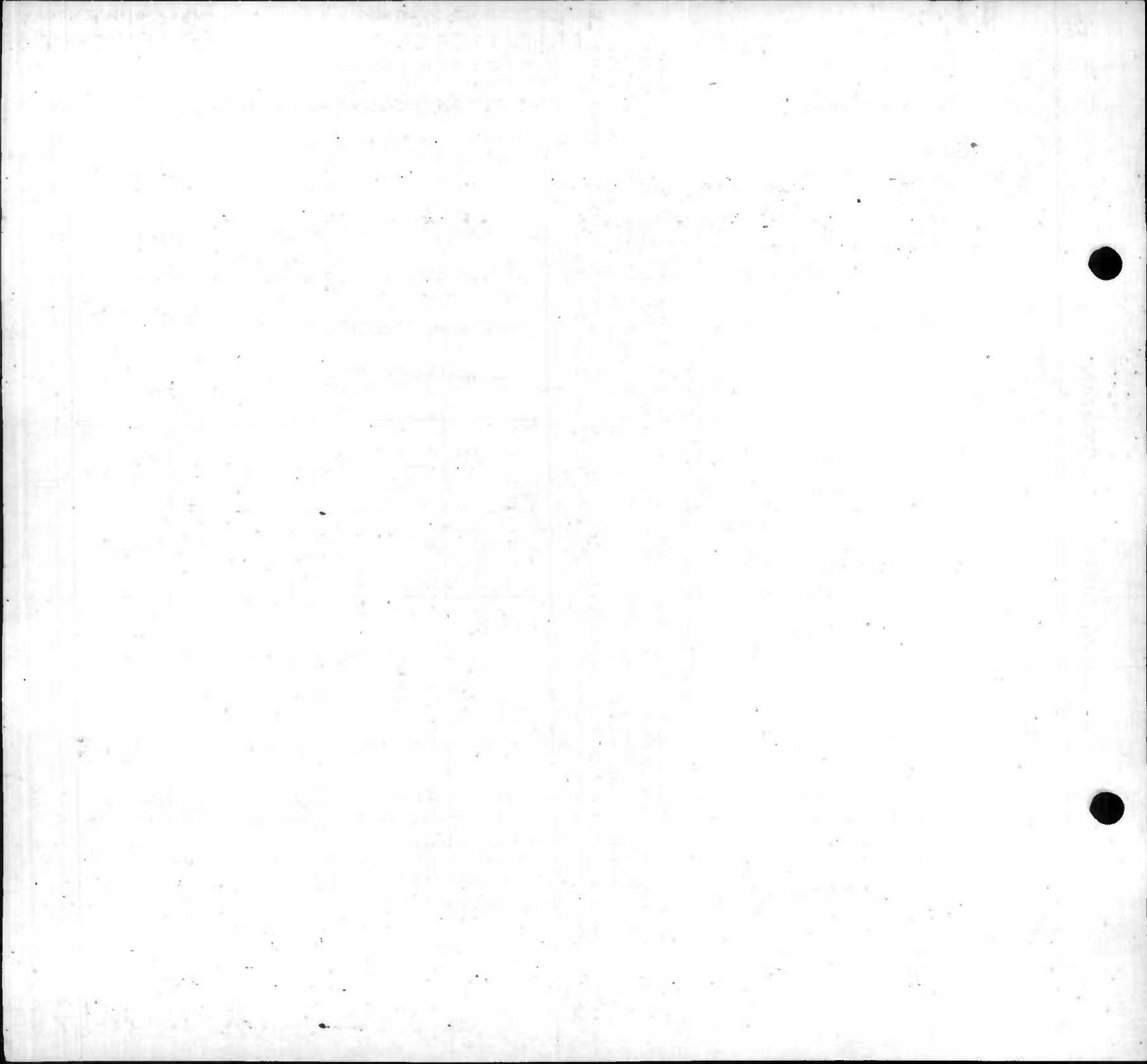
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 07870</u>	
BIRTH NO. <u>C-642</u> <u>72 07870</u>		1. NAME OF DECEASED (Type or Print) <u>Elsie J. Gerlach</u>		2. DATE AND HOUR OF DEATH <u>August 14, 1972</u>		STATE OF <u>MARYLAND</u> <u>4:30 A.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1816 North Broadway</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>806</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F.</u>		6. RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 18, 1883</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Julius G. Gerlach</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Riebel</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. David E. Brauer</u>	
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Cardiovascular Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>26 July</u> 19 <u>66</u> to <u>14 August</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>12 August</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE <u>John W. Barnaby</u> DEGREE	
23C. PHYSICIAN'S NAME (Type) <u>John W. Barnaby M.D.</u>		23D. ADDRESS <u>1652 East Belvedere Avenue</u>		23E. DATE SIGNED <u>15 Aug 72</u>		23F. Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/17/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 18 1972</u>		25B. NAME OF REGISTRAR <u>Sidney H. Weston</u>		25C. FUNERAL DIRECTOR <u>Henry Sander & Sons Inc.</u>		ADDRESS <u>Baltimore Maryland 21213</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07871	
C-423 72 07871				STATE OF MARYLAND - BALTIMORE	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Chilcoat, Lewis</u>		2. DATE AND HOUR OF DEATH <u>8/16/72</u> <u>6 20 AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE <u>MARYLAND</u> B. COUNTY <u>908</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>HAMILTON NURSING CENTER</u> <u>6040 HARFORD RD.</u> <u>BALTIMORE, MARYLAND</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>78</u> 9. AGE (In years last birthday) <u>78</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Probable Coronary Thrombosis</u> <u>Chronic Coronary Artery disease</u> <u>with history of auricular fibrillation</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>and cardiac failure</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____		Years <u>Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Parkinsonism</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>7-1</u> 19 <u>72</u> to <u>8-16</u> 19 <u>72</u> . that (H) (we) last saw the deceased alive on <u>8-16</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W.P. Benson, Jr. M.D.</u>		23B. DATE SIGNED <u>8-16-72</u>		23C. PHYSICIAN'S NAME (Type) <u>W. BENSON</u> M.D.	
23D. ADDRESS <u>3506 N. Calvert St</u>		23E. CITY, TOWN, OR COUNTY <u>Baltimore Md.</u>		23F. STATE <u>Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-18-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Md. National Mem Park</u>	
24D. LOCATION <u>Laurel Md.</u>		24E. CITY, TOWN, OR COUNTY <u>Laurel Md.</u>		24F. STATE <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 18 1972</u>		25B. NAME OF REGISTRAR <u>Dorothy Johnson</u>		25C. FUNERAL DIRECTOR <u>Paul E. Gammuto</u> ADDRESS <u>3615 Chestnut</u>	



CERTIFICATE OF DEATH

REG. NO.

72 07872

STATE OF MARYLAND-DEMD

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ardie M. Justice

2. DATE AND HOUR OF DEATH

8/13/72

1:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
4940 Eastern Ave. Baltimore, Md.

BALTIMORE CITY Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md

Baltimore

5300

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

2912 Liberty Parkway

5. SEX

Female

6. RACE

Caucasian

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

8/13/77

9. AGE (In years last birthday)

95

If Under 1 Yr. If Under 24 Hrs.

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Crockett

14. MOTHER'S MAIDEN NAME

MARY CARNEY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

220-52-7948T

17. INFORMANT

BCH Records:

4940 Eastern Ave. ADDRESS

Baltimore, Md. 21224

18.

436.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Respiratory Arrest

10 minutes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Stroke

6 days

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

None

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

None

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

None

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/8 1972 to 8/13 1972, that (I) (we) last saw the deceased alive on 8/13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Richard L. Sylvan

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

8/13/72

23C. PHYSICIAN'S NAME (Type)

Richard L. Sylvan M.D.

DEGREE

23D. ADDRESS Baltimore City Hospitals

4940 Eastern Ave. Baltimore, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/16/72

24C. NAME OF CEMETERY OR CREMATORY

Crisfield Cemetery

24D. LOCATION (City, town, or county)

Crisfield, Somerset, Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 18 1972

25B. NAME OF REGISTRAR

Bradshaw & Sons

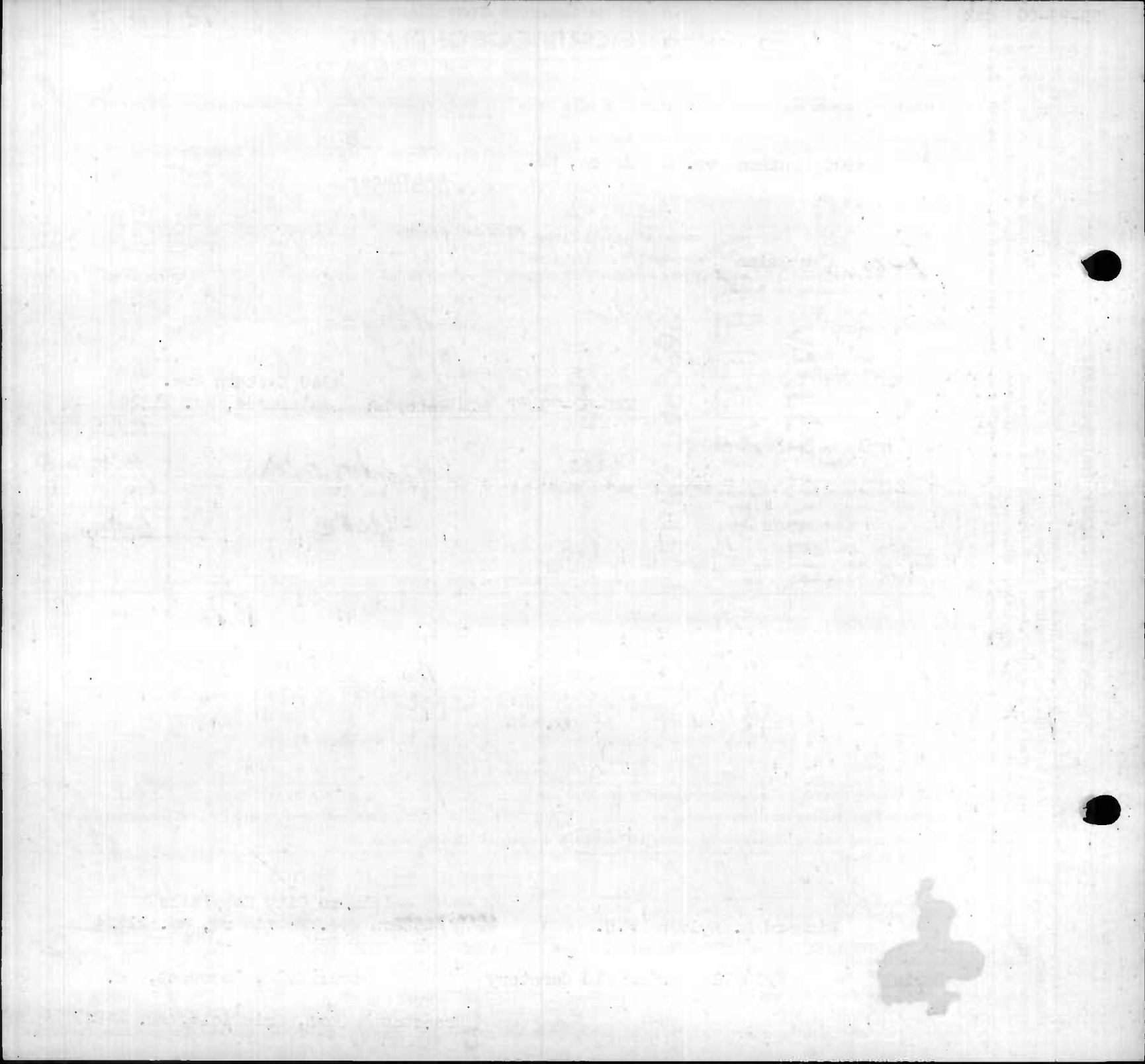
25C. FUNERAL DIRECTOR

Bradshaw & Sons, Crisfield, Md. 21817

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

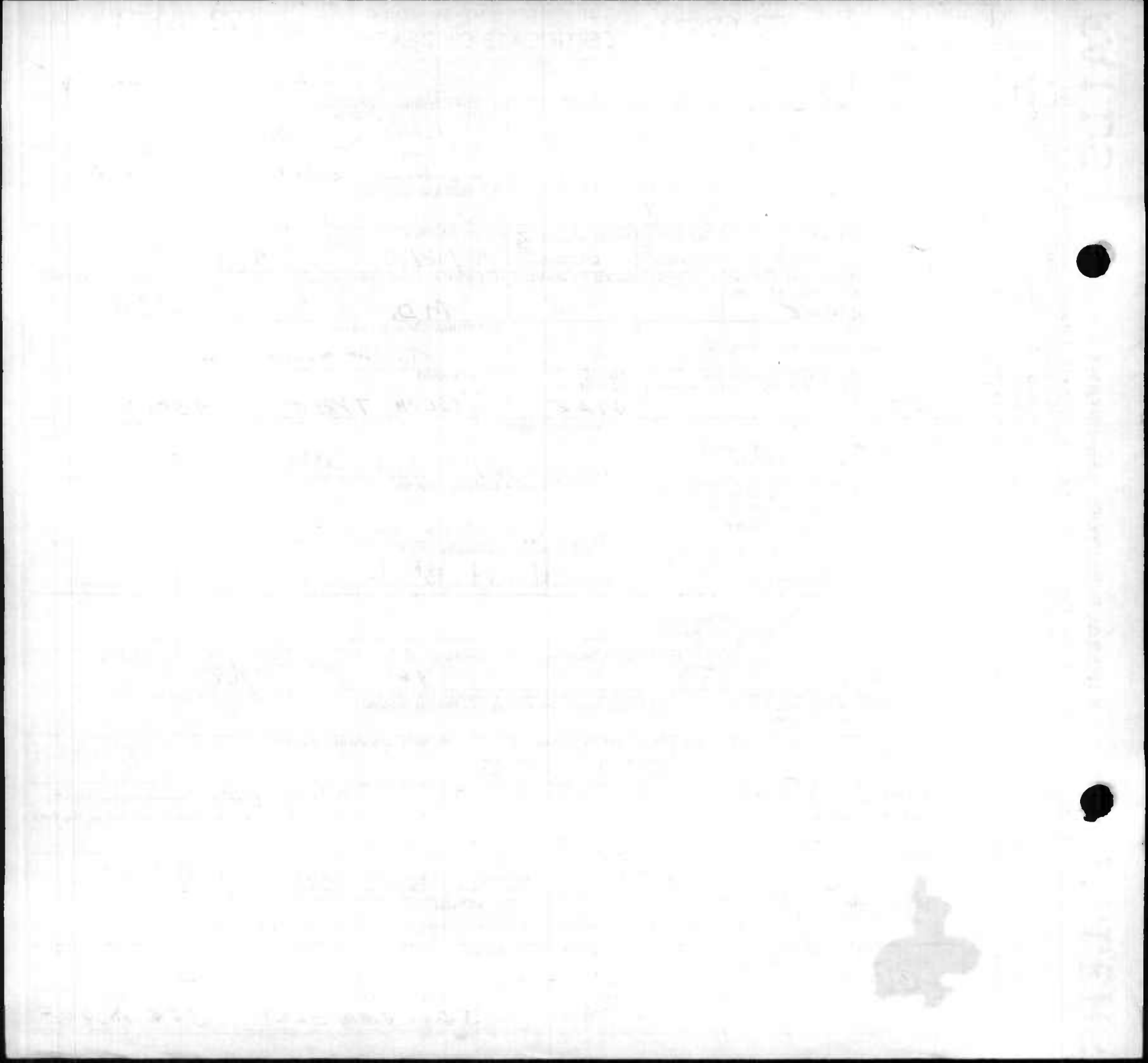
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07873	
T-600 72 07873				STATE OF MARYLAND-DHMH	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Tyree, Joseph, Jr.</u>				2. DATE AND HOUR OF DEATH <u>8/15/72</u> <u>1815</u> P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u> <u>JOHNS HOPKINS HOSPITAL</u> <u>601 N. BROADWAY</u>				C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>204 MIDDLEWAY</u>	
5. SEX <u>M</u>	6. RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/12/70</u>	9. AGE (In years last birthday) <u>1</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>M.D.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>JOSEPH P. TYREE</u>		
14. MOTHER'S MAIDEN NAME <u>CHRISTINA WILLIAMSON</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>NONE</u>			17. INFORMANT <u>JOSEPH TYREE</u> ADDRESS <u>ABOVE</u>		
18. CAUSE OF DEATH <u>746.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <u>VSD under aortic valve defect</u> DUE TO, OR AS A CONSEQUENCE OF:					
(B) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <u>Heart Block</u> DUE TO, OR AS A CONSEQUENCE OF:					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <u>8/14/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>VSD</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 4</u> 19 <u>72</u> to <u>Aug 15</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Aug 15</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jack A. Roth</u>				23B. DATE SIGNED <u>8/15/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jack A. Roth</u>				23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/18/72</u>		24C. NAME of CEMETERY or CREMATORY <u>HOLLY HILL</u>	
24D. LOCATION <u>BALTO. MD.</u>		24E. STATE <u>MD.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 18 1972</u>		25B. NAME OF REGISTRAR <u>Dorothy Whitton</u>		25C. FUNERAL DIRECTOR <u>J. G. CONNELLY</u> ADDRESS <u>300 MACE</u>	



P-625

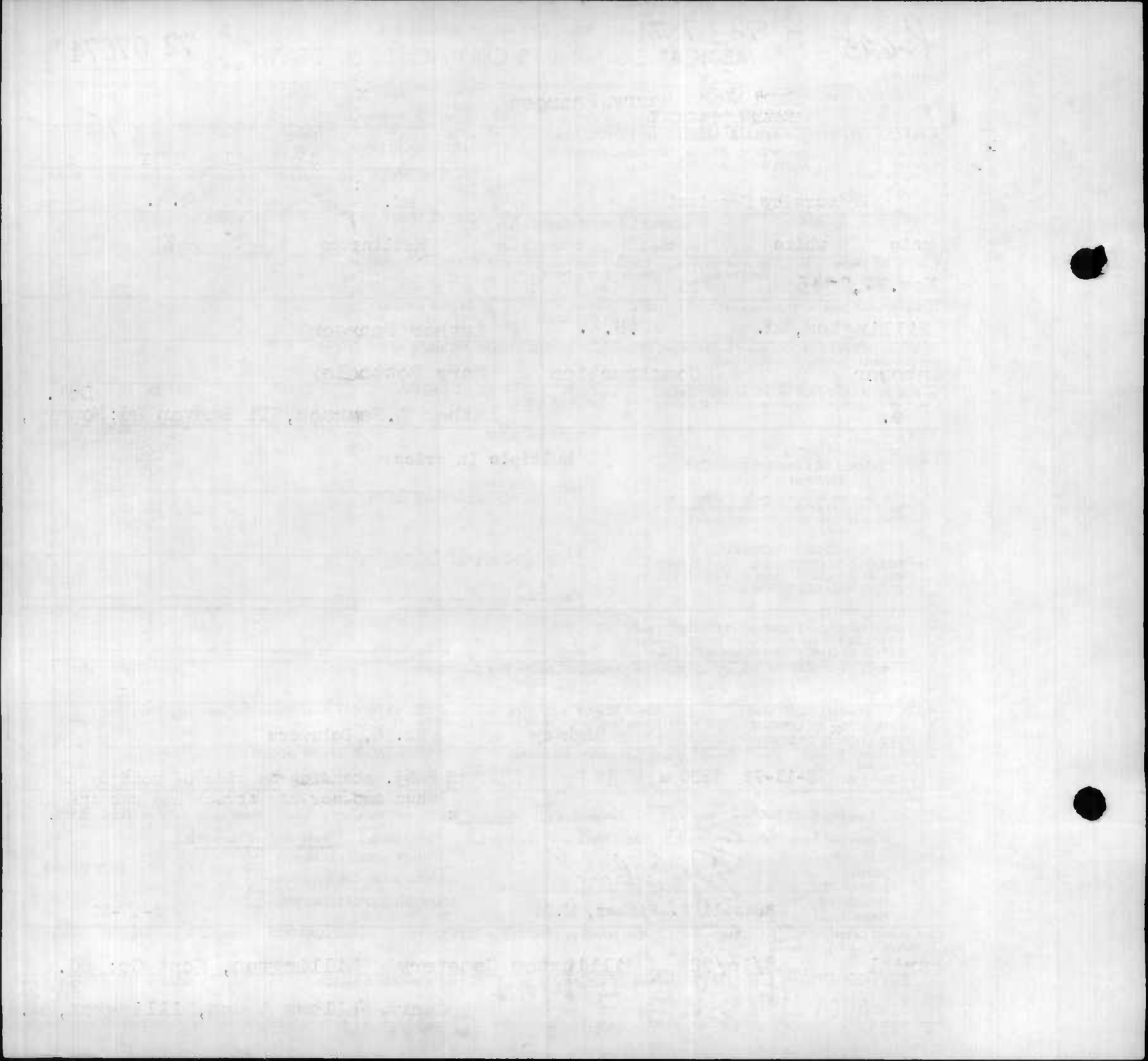
72 07874 STATE OF MARYLAND-DEMH
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07874

REG. NO.

BIRTH NO.

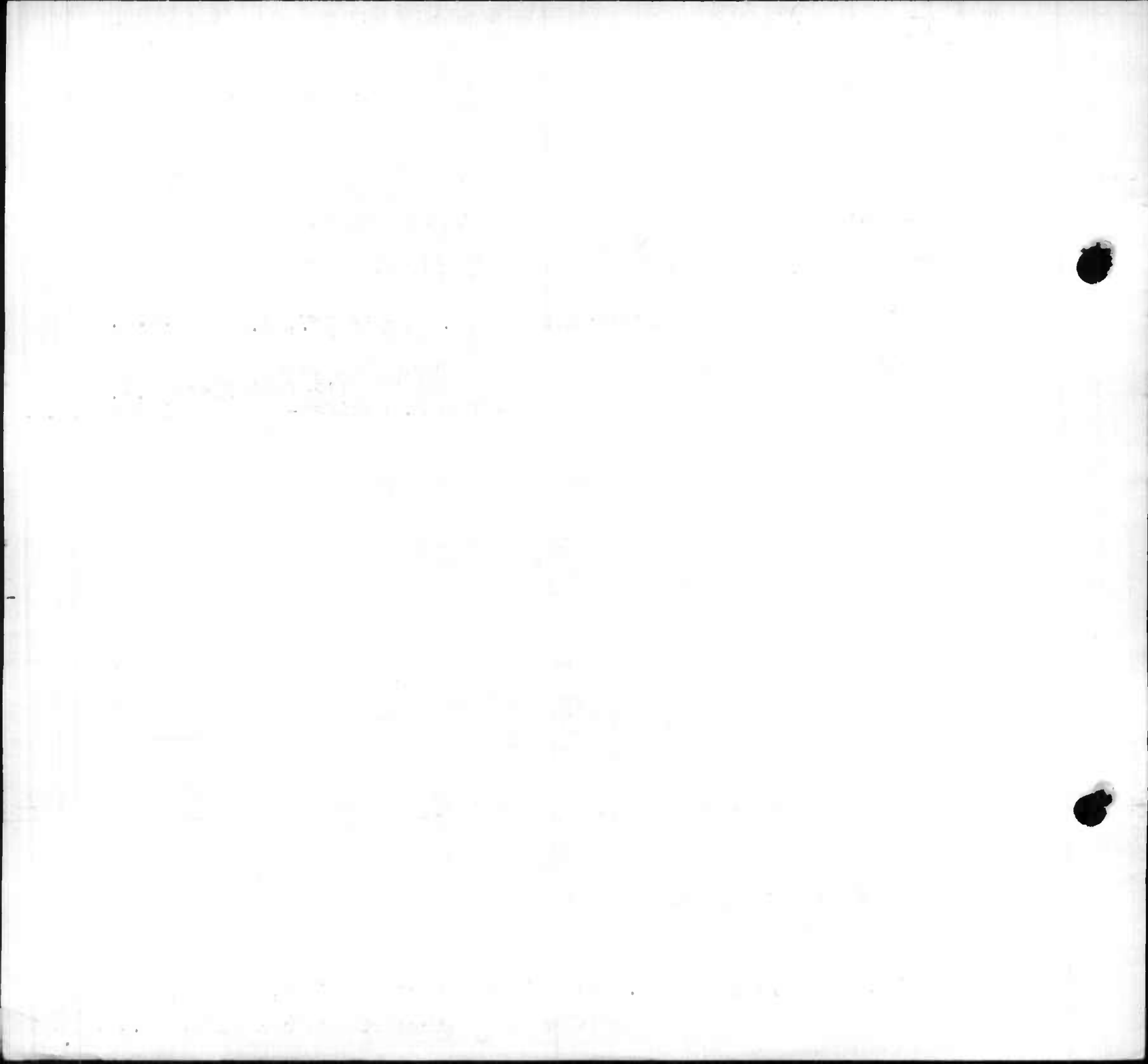
1. NAME OF DECEASED (Type or Print) Earl John Harry Pearson EARL J. PEARSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> _____ M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 13 1972 6 a M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Millington	
9. DATE OF BIRTH Nov. 27, 1945		10. AGE (In years last birthday) 26 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Millington, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Luther Pearson		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Q.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Construction	
15. MOTHER'S MAIDEN NAME Mary Bottomley		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.	
17. SOCIAL SECURITY NO.		18. INFORMANT Luther L. Pearson, 511 Banyan Rd; Newark, Del.	
19. E 788X		CAUSE OF DEATH Multiple injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) highway	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Rt. 6, Delaware		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 8-13-72 1:30 a	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subj. standing on side of road by car when another car struck his car and it	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> 8-14-72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/72	
24C. NAME OF CEMETERY or CREMATORY Millington Cemetery		24D. LOCATION (City, town, or county) (State) Millington, Kent Co; Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972		25B. NAME OF REGISTRAR Andrew M. ...	
25C. FUNERAL DIRECTOR Edward Fellows & Son, Millington, Md.		ADDRESS 21651	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07875	
J-516 72 07875				STATE OF MARYLAND - DEMU	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Jenifer, Catherine</u>				2. DATE AND HOUR OF DEATH <u>8-12-72</u> <u>11:55</u> P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Good Samaritan Hosp.</u>				A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u>	
5. SEX <u>F</u> 6. RACE <u>B</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>				E. STREET AND NUMBER <u>6601 Baltimore National Pike</u>	
10B. KIND OF BUSINESS OR INDUSTRY <u>Restaurants</u>				8. DATE OF BIRTH <u>5-31-15</u> 9. AGE (in years last birthday) <u>57</u>	
13. FATHER'S NAME <u>Columbus Thomas Bowman</u>				11. BIRTHPLACE (State or foreign country) <u>St. Mary's Co., Md.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
16. SOCIAL SECURITY NO. <u>218-13-2886</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wilson</u>	
17. INFORMANT <u>James A. Jenifer-</u>				ADDRESS <u>112 Todd Place N.E. Washington, D.C.</u>	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Squamous cell Ca of</u> <u>7 years</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>lung metastases</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/15</u> 19 <u>72</u> to <u>8/12</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/12</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard J. Sweller M.D.</u>				23B. DATE SIGNED <u>8/12/72</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/16/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Joseph's Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 18 1972</u>		25B. NAME OF REGISTRAR <u>Richard J. Sweller</u>		25C. FUNERAL DIRECTOR <u>3 Grehart Funeral Home, Inc., La Plata Md.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-650		72 07876		CITY HEALTH DEPARTMENT		REG. NO. 72 07876	
BIRTH NO.				STATE OF MARYLAND - DISTRICT			
1. NAME OF DECEASED (Type or Print) <i>Drewen Pearl E</i>				2. DATE AND HOUR OF DEATH <i>4:45 pm 8/14/72</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>33</i> JOHNS HOPKINS HOSPITAL BALTIMORE, MARYLAND 21205				A. STATE MD. B. COUNTY ANNE ARUNDEL <i>5200</i>			
				C. CITY OR TOWN GLEN BURNIE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 6903 GLEN RIDGE CIRCLE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/06/50	9. AGE (In years last birthday) 21	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sales Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Department Store</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME JOHN FORD				14. MOTHER'S MAIDEN NAME ANNA WATERS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. 214 50 7699		17. INFORMANT Husband: <i>Glen Burnie, Maryland</i> <i>Ronald W. Drewen 6903 Glen Ridge Circle</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 1. S.I.X. I CONCOMITANT Chono - E pyram or bleed (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (1) Pancytopenia 2° MTK tox (2) CHF (3) Chono cancer metastatic 8/14/72				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8/14/72</i>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>7/30/72</i> 19__ to <i>8/14/72</i> 19__ that (I) (we) last saw the deceased alive on <i>8/14/72</i> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Norman H. Darkoku</i>				23B. DATE SIGNED <i>8/14/72</i>		23C. PHYSICIAN'S NAME (Type) <i>NORMAN H. Darkoku</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>8/17/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Security Process, Inc.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Balto., Co., Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972		25B. NAME OF REGISTRAR <i>11672000</i>		25C. FUNERAL DIRECTOR ADDRESS <i>McGully Funeral Home Mountain & Tick Neck Rds.</i>			

ATTACHED TO THE
REPORT OF THE

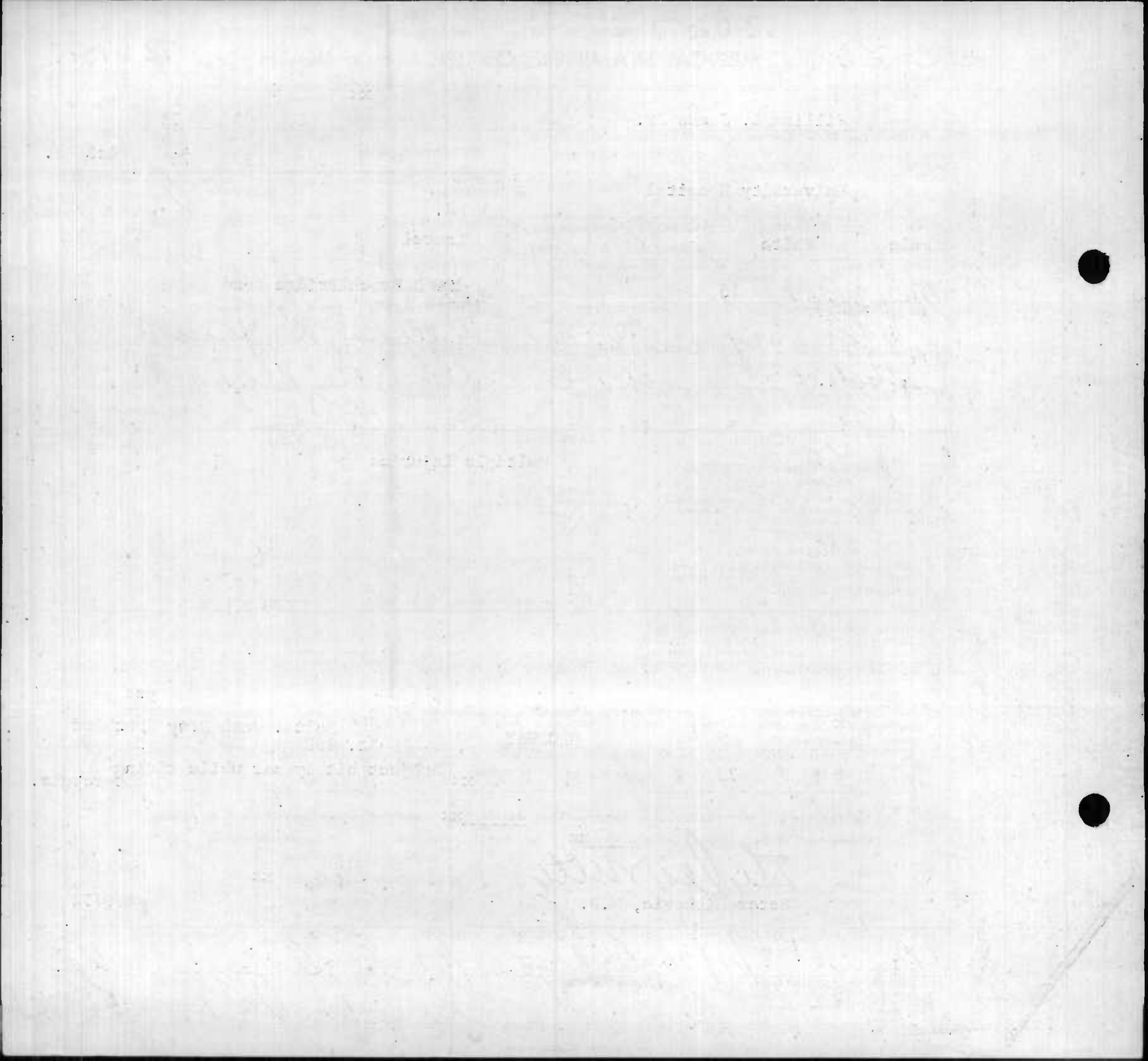
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07877

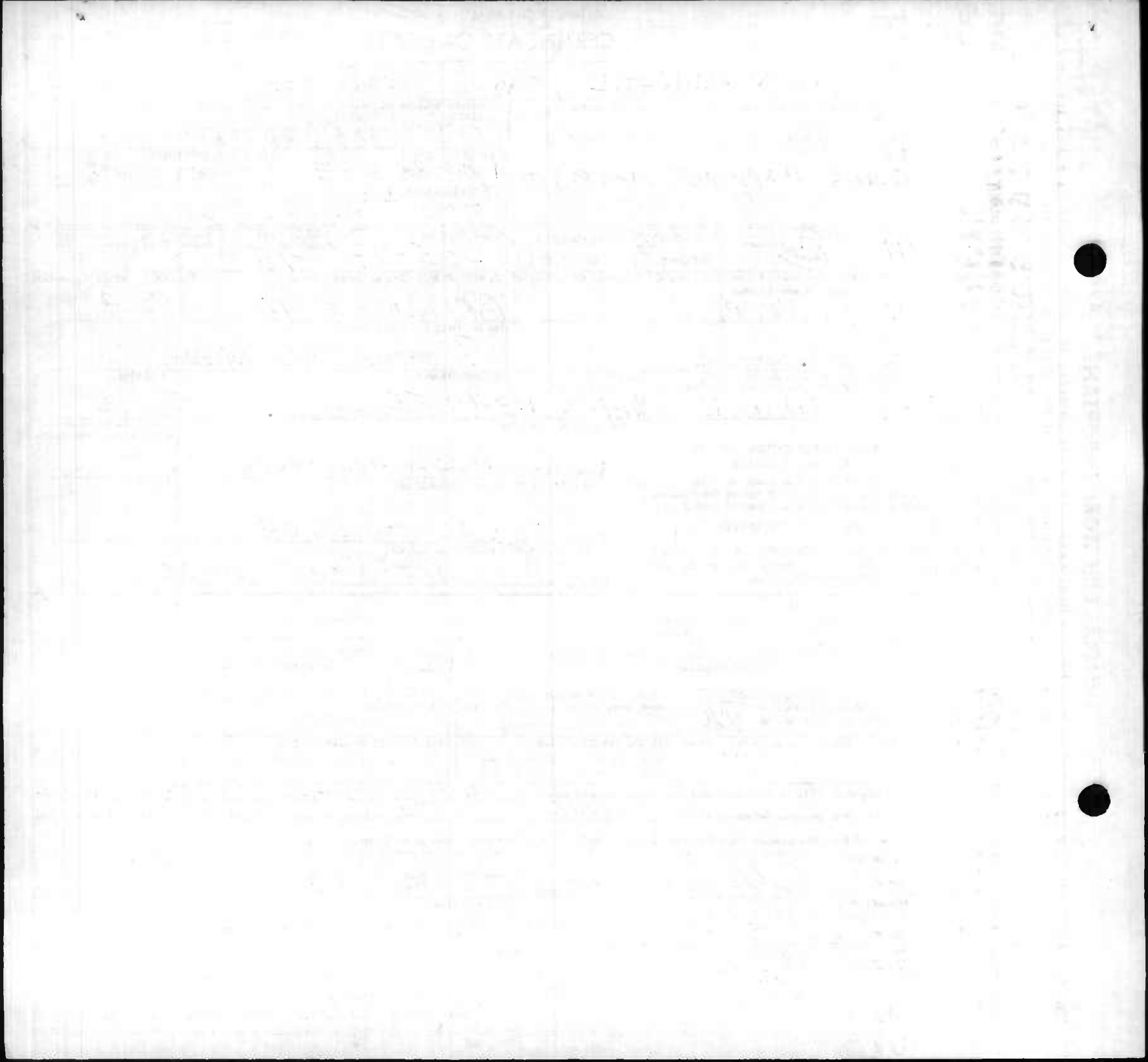
BIRTH NO.

1. NAME OF DECEASED (Type or Print) William L. Jones Jr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 8 9 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 9 72 4:30 a. M.	
6. SEX male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE White		C. CITY OR TOWN Laurel	
9. DATE OF BIRTH May 7, 1957		10. AGE (In years last birthday) 15	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William L. Jones		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student	
15. MOTHER'S MAIDEN NAME Lieselotte Diebold		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO.		18. INFORMANT Lieselotte Jones - same as #5	
19. E 812.13		CAUSE OF DEATH Multiple injuries	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HIGHWAY		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Balto. Wash Pkwy South of Rt. 198	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour 8 9 9 72 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Subject hit by car while riding motorcycle.		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Peter Lipkovic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/9/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/11/72	
24C. NAME OF CEMETERY or CREMATORY Arlington National		24D. LOCATION (City, town, or county) (State) Arlington Va	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972		25B. NAME OF REGISTRAR Shirley	
25C. FUNERAL DIRECTOR Canadian Funeral Home Inc.		ADDRESS Laurel	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death. Such deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07878	
N-163 72 07878		STATE OF MARYLAND - DHMH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) FRANK NAURATIL, SR.		15 AUG 1972 10:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		A. STATE MD. B. COUNTY DORCHESTER	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN CAMBRIDGE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
33		E. STREET AND NUMBER 703 TRAVERS ST.	
5. SEX M	6. RACE C W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1-25-97
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
SECURITY GUARD		BALTIMORE, MD.	
13. FATHER'S NAME Frank J. Navratel		14. MOTHER'S MAIDEN NAME Barbara Nekola Navaratel	
15. Was Deceased Ever in U. S. Armed Forces? (Yes or no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 214-12-6183	
YES W.W.I		17. INFORMANT WIFE Margaret P. ADDRESS SAME	
18. 441.91		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE CARDIAC ARREST	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(B) RENAL FAILURE	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) AORTIC ANEURYSM RUPTURE	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5 AUG 1972 to 15 AUG 1972 that (I) (we) last saw the deceased alive on 15 AUG 1972 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Neill S. Hirst MD		23B. DATE SIGNED 15 AUG 72	
23C. PHYSICIAN'S NAME (Type) NEILL S. HIRST MD		23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/18/72	
24C. NAME OF CEMETERY OR CREMATORY Our Lady of Good Council		24D. LOCATION (City, town, or county) (State) Secretary Dor MD	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972		25B. NAME OF REGISTRAR LeCompte	
25C. FUNERAL DIRECTOR LeCompte		ADDRESS Funeral Home Cambridge MD	



72 07879

STATE OF MARYLAND-DEHE
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07879

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CLARENCE DECATUR

2. DATE
OF DEATHKnown ☒
Estimated ☐

Month

Day

Year

Hour

August 10, 1972

9:00 A.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

August 10, 1972

9:00 A.

5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)

A. STATE Maryland

B. COUNTY

Prince Georges

C. CITY OR TOWN

East Riverdale

D. INSIDE CITY LIMITS?

YES ☒No ☐

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

18 Aug 1922

10. AGE (In years
lost birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

6318 - 57th Avenue

11. BIRTHPLACE (State or foreign country)

District of Columbia

12. CITIZEN OF

WHAT COUNTRY?
U.S. America

13. FATHER'S NAME

Thomas Edward Decatur

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Iron Worker

14B. KIND OF BUSINESS OR INDUSTRY

Construction

15. MOTHER'S MAIDEN NAME

Rosalee Decatur

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

17. SOCIAL
SECURITY NO.

578-09-8148

18. INFORMANT

Elizabeth Decatur

ADDRESS

same as #18 50

19.

E 881 X1

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Cerebro-cranial injuries
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)
Construction Site22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?
Lusby, Md. (Bectel Corp.)22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) 8-3-72 10:00 A.22E. INJURY OCCURRED
WHILE AT WORK ☒ NOT WHILE
AT WORK ☐22F. HOW DID INJURY OCCUR?
Subject an iron-worker who fell from
a scaffold onto concrete

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kormblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 10, 1972

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

14 Aug 1972

24C. NAME of CEMETERY or CREMATORY

Fort Lincoln Cem.

24D. LOCATION (City, town, or county)

Colmar Manor, Pr. Geo, MD.

25A. DATE REC'D BY HEALTH DEPT.

AUG 18 1972

25B. NAME OF REGISTRAR

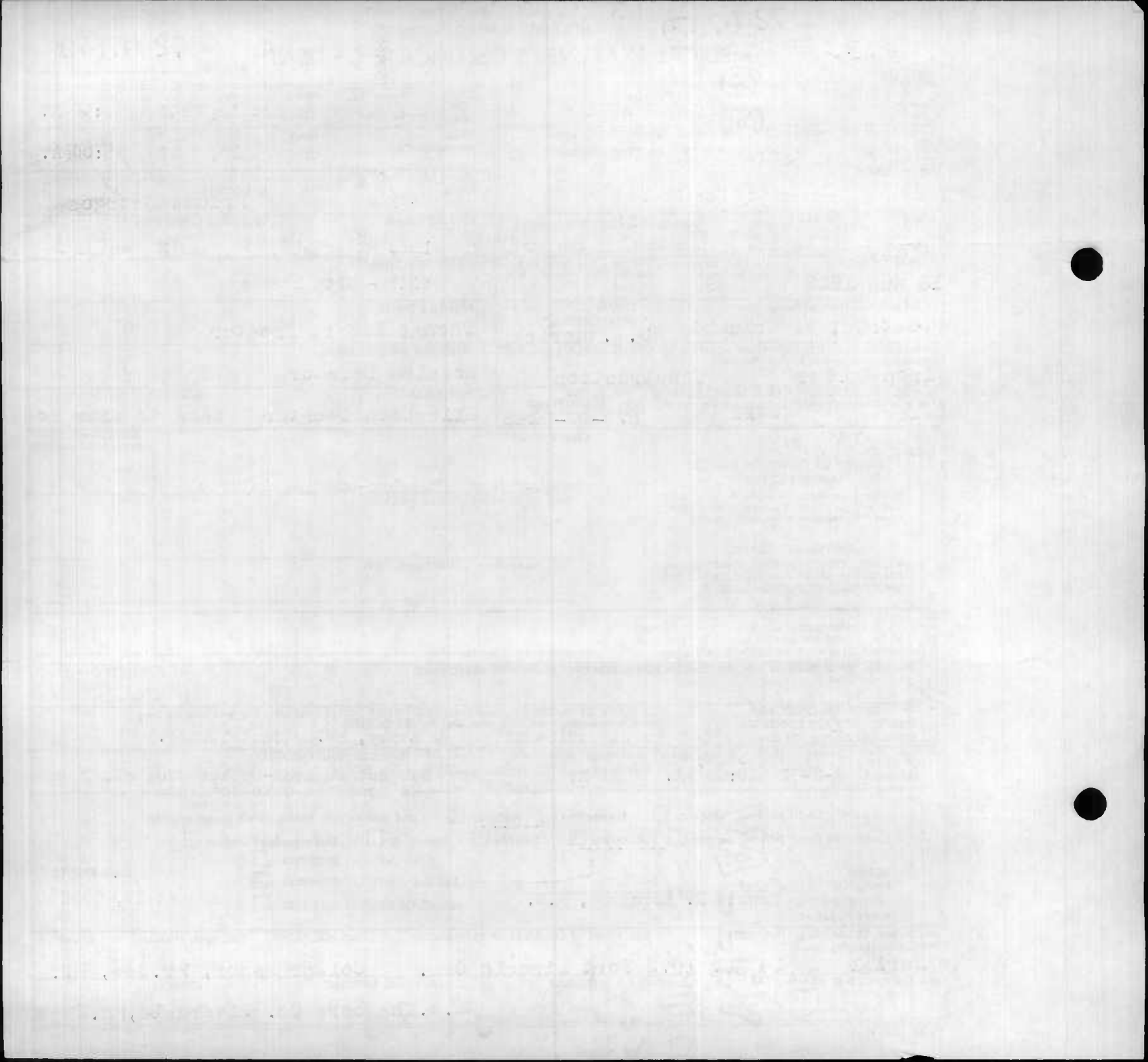
Arlene H. Heston

25C. FUNERAL DIRECTOR

W. W. Chambers Co. Riverdale, Md. 20840

ADDRESS

N 854.0

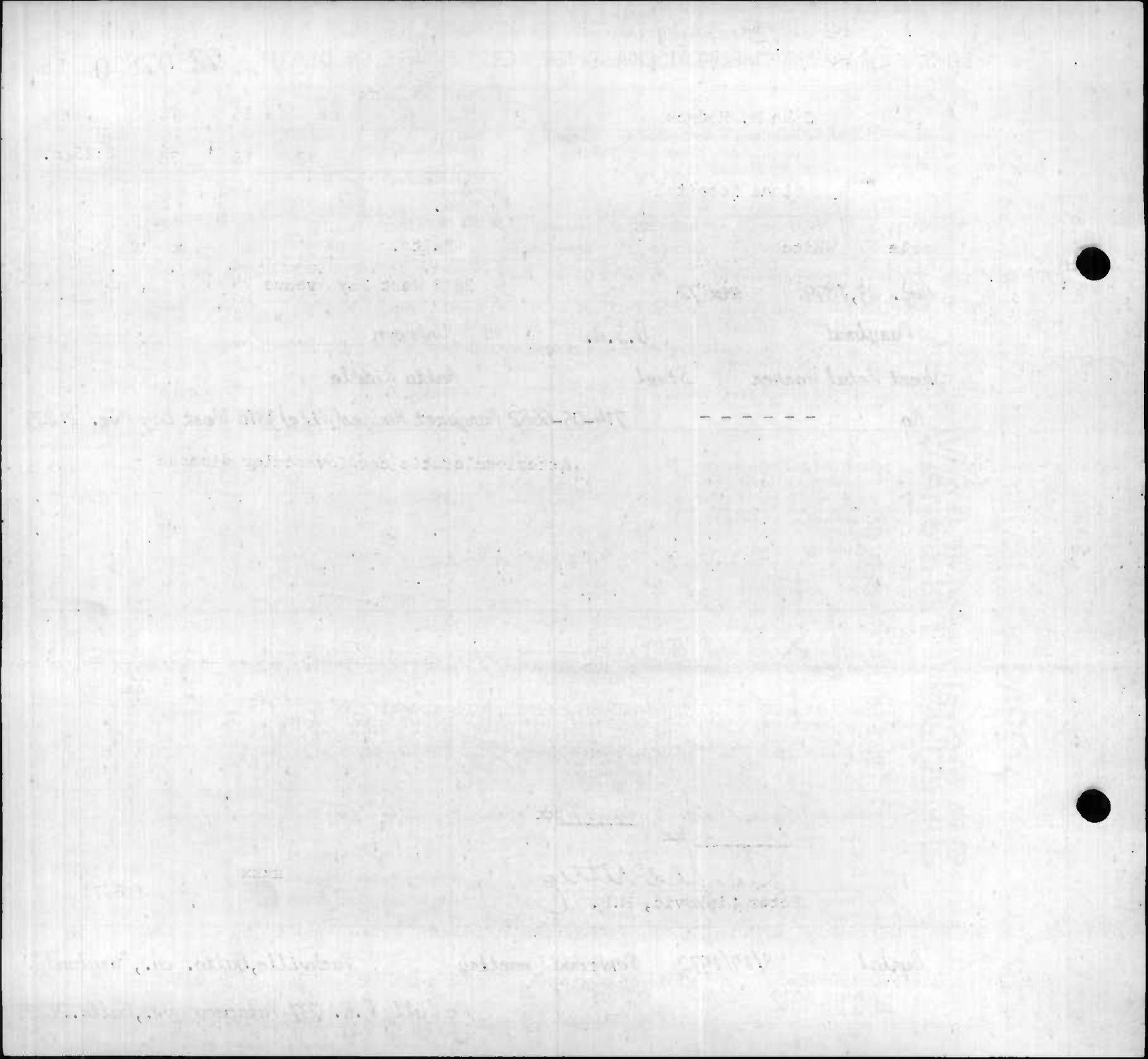


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07880

BIRTH NO.

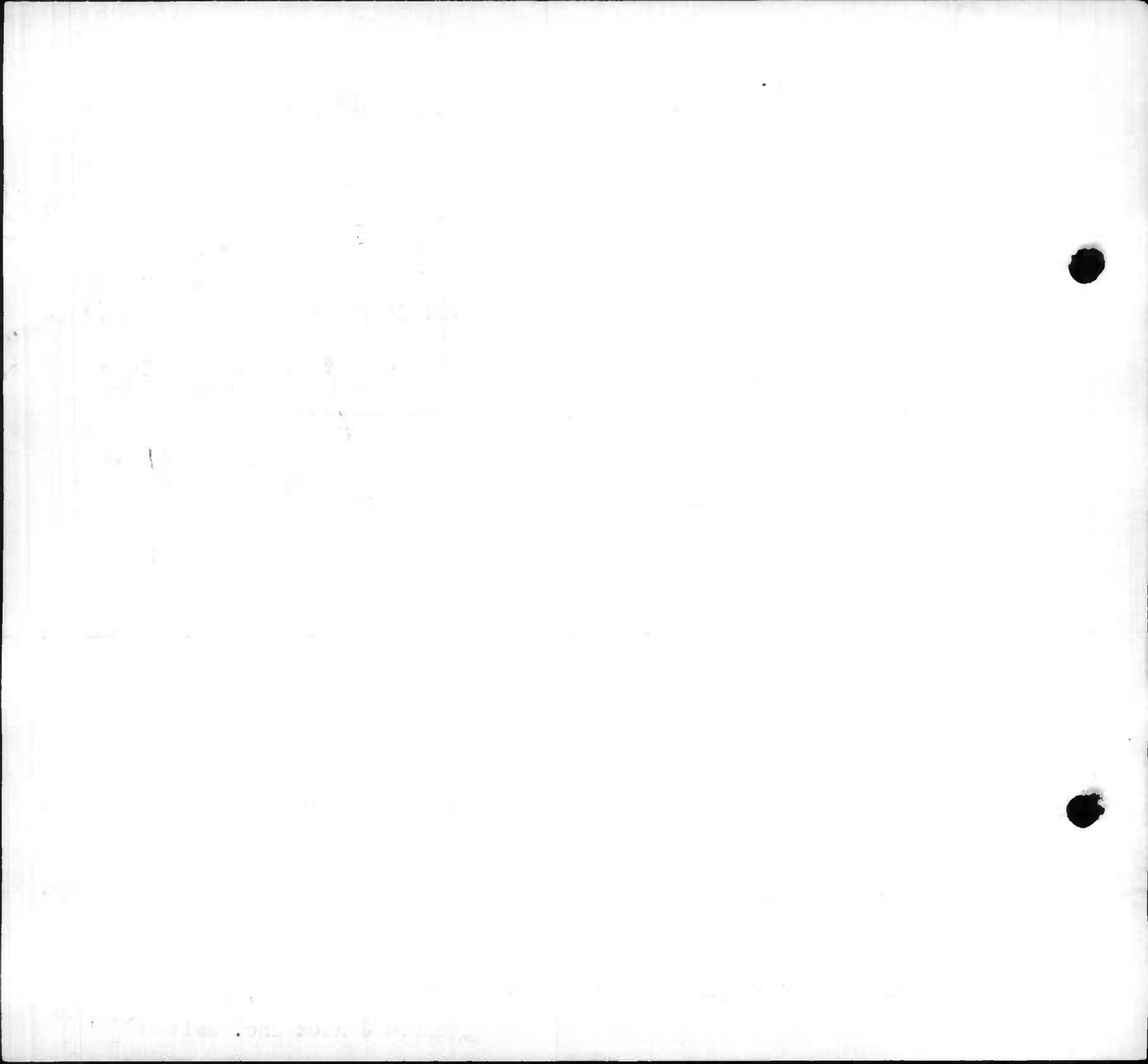
1. NAME OF DECEASED (Type or Print) John M. Hodges		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 8 16 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 16 72 8:25 a. M.	
6. SEX male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2505	
9. DATE OF BIRTH Aug. 23, 1899		10. AGE (In years last birthday) 72	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Anita Riddle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 714-05-6682	
17. INFORMANT Margaret Hodges (Wife)		18. ADDRESS 3816 West Bay Ave. 21225	
19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 8/12/72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/16/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/19/1972	
24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Parkville, Balto. co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972		25B. NAME OF REGISTRAR Andrew Johnson	
25C. FUNERAL DIRECTOR Mc Cully F.H.		25D. ADDRESS 237 Patapsco Ave., Balto. 21225	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-613		72 07881		BALTIMORE CITY HEALTH DEPARTMENT		72 07881	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH				STATE OF MARYLAND - DEW	
BERTHA M. THRIFT		Aug 16 12:01 A.M.				MD BALTO 5300	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MD		BALTIMORE		7600 OLD HARFORD RD	
GOOD SAMARITAN HOSPITAL 45		E. STREET AND NUMBER		7600 OLD HARFORD RD			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/13	9. AGE (In years last birthday) 58	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN ROTH		14. MOTHER'S MAIDEN NAME ANTONIA KROLUS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213 20 164	
17. INFORMANT Leonard F Thrift		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) METASTATIC BREAST CANCER DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. DATE OF OPERATION 174X I		20. AUTOPSY? (Yes or No) Same	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 10 August 1972 to 16 August 1972 that (I) (we) last saw the deceased alive on 15 August 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE [Signature]	
23B. PHYSICIAN'S NAME (Type)		23C. ADDRESS		23D. DATE SIGNED 16 August 1972		23E. ATTENDING PHYSICIAN Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/19/72		24C. NAME of CEMETERY or CREMATORY Moreland Memorial Pk		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR Leonard J Ruck Inc.		25D. ADDRESS Baltimore, MD	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 07882		72 07882	
C-666		72 07882		72 07882	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ARTHUR W. CRYER		AUG. 16, 1972 4:07 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		Balto.	
SOUTH BALTIMORE GENERAL HOSPITAL		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		PADOXIA RD. 1/2 MI. N. E. OF BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		88 PADOXIA ROAD			
6. SEX	7. RACE	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. DATE OF BIRTH	10. AGE (In years last birthday)	11. If Under 1 Yr. Months Days
MALE	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8-10-11	61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Accountant		Automotive		Eth. England	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Joseph CRYER		Ethel KNIGHT		U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		321-05-9037		Mrs. Maxine Cryer	
18. CAUSE OF DEATH		88 Padoxia Rd. Timonium, Md 21093		ADDRESS	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		MYOCARDIAL INFARCTION		3 WKS	
ANTECEDENT CAUSES		(B) CORONARY ARTERY DISEASE		3+ WKS.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7/26 1972 to 8/16 1972 that (I) (we) last saw the deceased alive on 8/16 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Robert J. Bauer, M.D.		8/16/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ROBERT J. BAUER, M.D.		3001 S. HANOVER ST. BALT., MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		Aug. 18, 1972		Hereford Baptist Cem.	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR	
Hereford, Balto. Co., Md.		James J. Wartenstein		New Freedom Pa.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 18 1972		James J. Wartenstein		New Freedom Pa.	

1937-1938

1937-1938

1937-1938

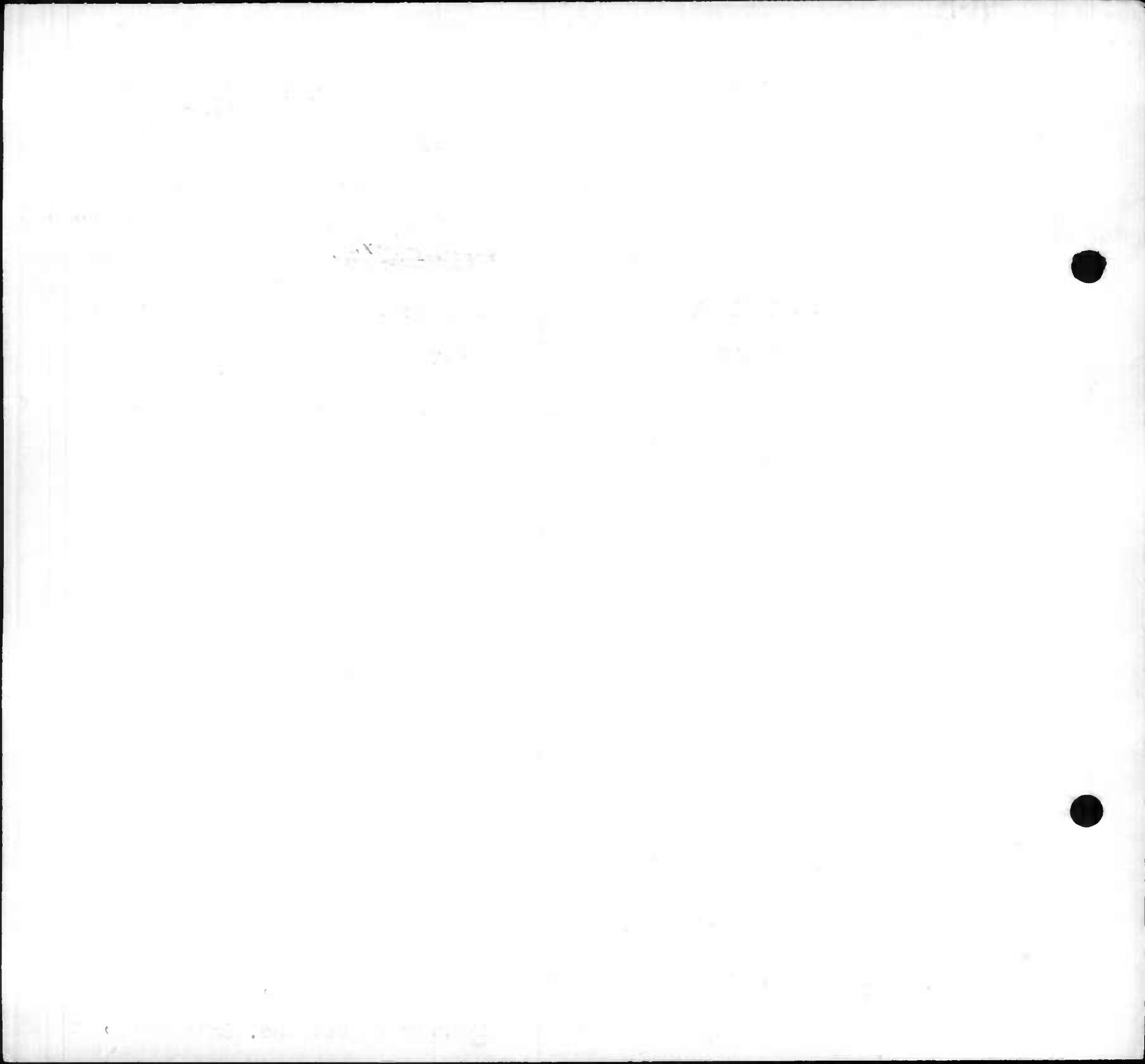
1937-1938

1937-1938

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-500		72 07883		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07883	
CERTIFICATE OF DEATH				STATE OF MARYLAND - DEATH			
1. NAME OF DECEASED (Type or Print) <i>SHEEHAN, Henry P.</i>				2. DATE AND HOUR OF DEATH <i>12:30 A.M. 8/17/72</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>91 Montebello State Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>MD (city)</i> B. COUNTY <i>2744</i>			
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-2-1905</i> 9. AGE (in years last birthday) <i>67</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Postal Clerk</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>Dennis Sheehan</i>			
14. MOTHER'S MAIDEN NAME <i>Mary Moore</i>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO.				17. INFORMANT <i>wife</i> ADDRESS <i>3507 Hamilton Ave 21214 Balt. Md.</i>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Arteriosclerotic Cardiovascular changes</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Right Hemiplegia</i>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Kameel F. Farag M.D.</i>				23B. DATE SIGNED <i>8/17/72</i>		23C. PHYSICIAN'S NAME (Type) <i>KAMEEL F. FARAG M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>8/19/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Greenmount</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 18 1972</i>		25B. NAME OF REGISTRAR <i>Adrian Thornton</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc.</i>		ADDRESS <i>Baltimore, Md</i>	



72 07884

BALTIMORE CITY HEALTH DEPARTMENT

72 07884

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Fannie V. Bates		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 8 16 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If not in hospital or institution, give street address or location) 00 1528 W. Fayette Street		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 16 72 12:55 a. M.	
6. SEX female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH June 1, 1935		10. AGE (In years last birthday) 37	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Bates		14. MOTHER'S MAIDEN NAME Jinnie Hawkins	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cancer of breast with metastases (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20. DATE OF OPERATION	
21. AUTOPSY? (Yes or No) no		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
23. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
25. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.)		26. HOW DID INJURY OCCUR?	
27. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		28. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
29. ACTUAL SIGNATURE Peter Lipkovic, M.D.		30. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
31. EXAMINER'S NAME (Type)		32. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
33. DATE 8-19-1972		34. LOCATION (City, town, or county) (State) Baltimore Md.	
35. DATE REC'D BY HEALTH DEPT. AUG 18 1972		36. NAME OF REGISTRAR Andrew J. Horton	
37. FUNERAL DIRECTOR Charles Evans Hughes		38. ADDRESS 1532 Hollins St.	

1960 57

1960 57

UNITED STATES DEPARTMENT OF AGRICULTURE

WATER RESOURCES DIVISION

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UNITED STATES DEPARTMENT OF AGRICULTURE

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UNITED STATES DEPARTMENT OF AGRICULTURE

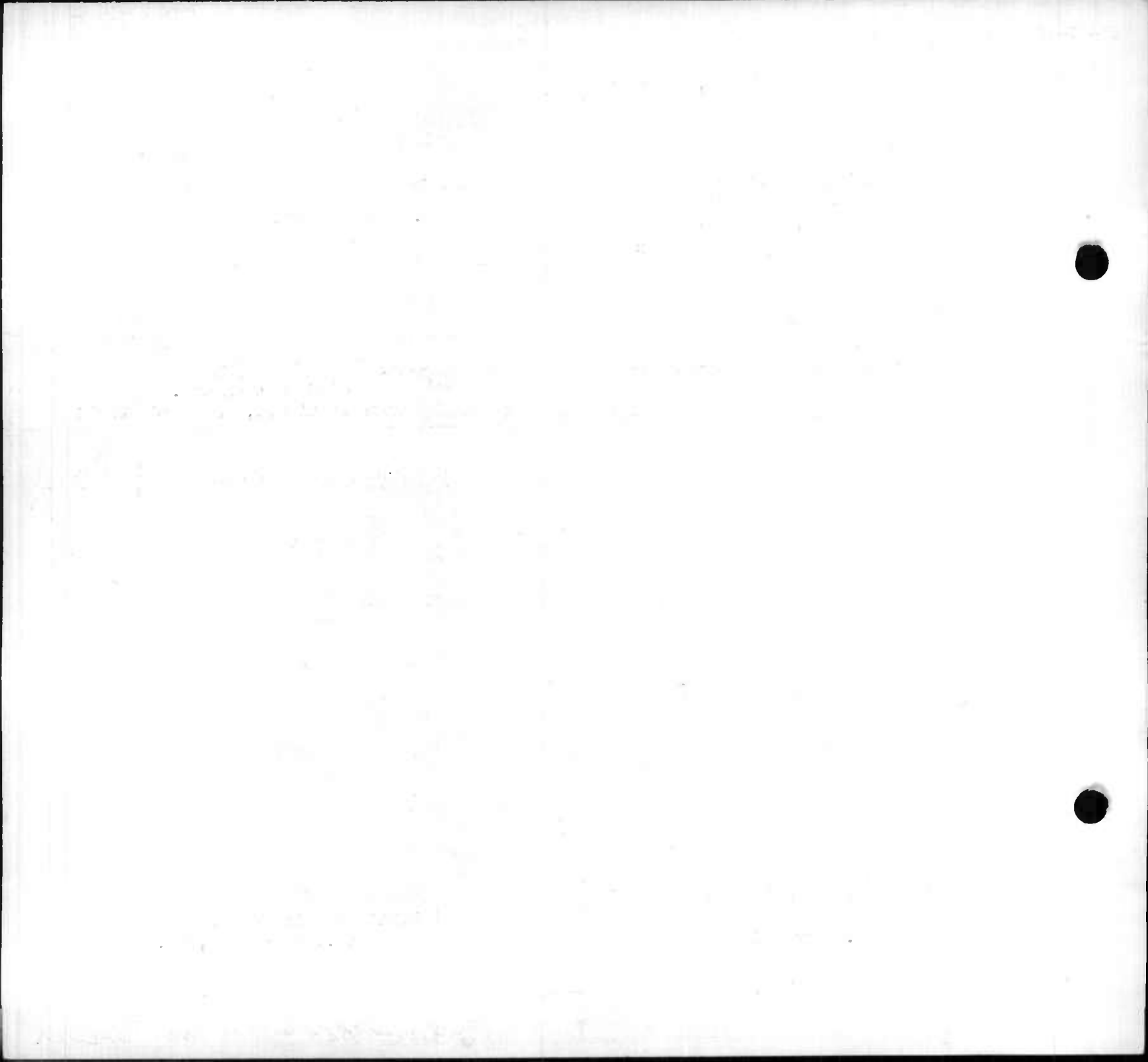
WATER RESOURCES DIVISION

61-67-99 gpw

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

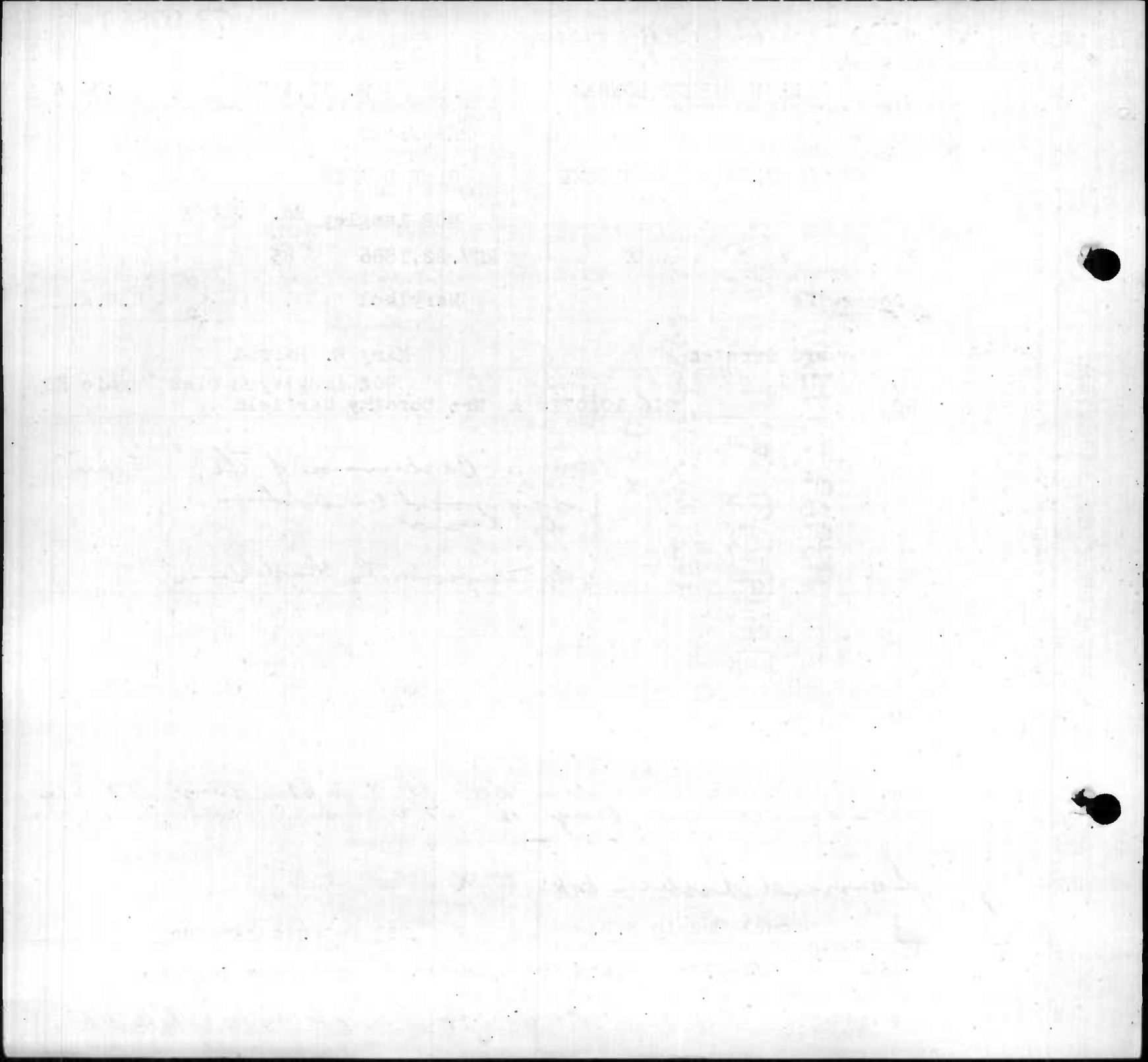
BIRTH NO.		72 07885		BALTIMORE CITY HEALTH DEPARTMENT		72 07885	
1. NAME OF DECEASED (Type or Print)		Brulinski, Florence, R.		2. DATE AND HOUR OF DEATH		8/17/72 1:05 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 504 S. Macon Street			
5. SEX Female	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/15/24		9. AGE (In years last birthday) 48	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILBERT SMITH				14. MOTHER'S MAIDEN NAME MARGARET ESLER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-14-3793		17. INFORMANT 4940 Eastern Ave. ADDRESS BCH RECORDS: Baltimore, Maryland 21224			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Uremic coma 4 days (B) CA of cervix 5 yrs (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/17/72 to 8/17/72 that (I) (we) last saw the deceased alive on 8/17/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. Fine MD				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) M. Fine MD				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave., Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-21-72		24C. NAME of CEMETERY or CREMATORY OAK LAWN		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972		25B. NAME OF REGISTRAR Andrew H. Hinton		25C. FUNERAL DIRECTOR JOHN M. WEBER & SONS INC.		ADDRESS 401 S. CHESTER	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-550		72 07886		BALTIMORE CITY HEALTH DEPARTMENT		72 07886	
BIRTH NO.		72 07886		REG. NO.		72 07886	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
LEAH HARROD LOWMAN				AUG. 17, 1972 2:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
CATON MANOR NURSING HOME				MARYLAND			
90				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				GLEN BURNIE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER			
				902 Langley Rd. 21061			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	NOV. 22, 1886	85	Housewife	Maryland	U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Howard Sweeten				Mary E. Harrod			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				216 10 0728 A		902 Langleyrd Glen Burnie MD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		3 yrs	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) arteriosclerotic Heart Disease			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 15 1967 to Aug 17 1972, that (I) (we) last saw the deceased alive on Aug 16 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Samuel Rubin M.D.							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Samuel Rubin M.D.				203 Patapsco Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/19/72		Govans Presbyterian		Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 18 1972		Henry Sander & Sons Inc		Baltimore Md			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> S-561 72 07887 72 07887 </div>		<div style="display: flex; justify-content: space-between;"> 72 07887 CERTIFICATE OF DEATH </div>		<div style="display: flex; justify-content: space-between;"> REG. NO. STATE OF MARYLAND </div>	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SOMERVILLE MR EDEAR W.		August 17, 1972 4:25 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. AGE (In years last birthday)	
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
BON SECOURS HOSPITAL		MARYLAND		1202	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		3220 BARCLAY ST. 21218			
6. SEX	7. RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. DATE OF BIRTH	10. AGE (In years last birthday)	11. If Under 1 Yr. Months: Days: Hours: Min.
MALE	BLACK	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6/21/1898	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
ENGINEER		DRPT OF Education		BALTO. MARYLAND	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
USA		EDGAR F. Somerville		ALice TERREL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		217-03-9253		Hospital Chart	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		Hepatic coma	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B)		Liver cirrhosis	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
		(C)		renal failure.	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
8-1-1972		Exp Lap		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinite medical examination)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
W. Azme					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Walid M. AZMEH					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		8/21/72		Mt. Auburn Cem.	
24D. LOCATION		24E. CITY, town, or county		24F. (State)	
BALTO. MD.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG-18 1972		Sidney Johnston		Sarah W. Hayes 3112 Reisterstown Rd.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-260		72 07888		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07888	
BIRTH NO.				STATE OF MARYLAND-DEPT.			
1. NAME OF DECEASED (Type or Print) BOOKER, RUSSEL				2. DATE AND HOUR OF DEATH AUG. 13 1972 10:00 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2798 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4971 EDMERE AVE			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-22-14	9. AGE (in years last birthday) 58	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) porter			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME SAMUEL BOOKER				14. MOTHER'S MAIDEN NAME SADIE CHEEKS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218073580		17. INFORMANT Ollie Hicks		ADDRESS same	
18. I I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ADENOCARCINOMA OF LUNG				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). underly metastatic disease							
19A. DATE OF OPERATION 2 NOV		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that the (this hospital) attended the deceased from 7/7 19 72 to 8/13 19 72 that (I) lost saw the deceased alive on AUG 13 19 72 and that in (my) lost opinion death occurred on the date and hour and from the causes stated above. (I) did not view the body after death.							
23A. SIGNATURE A. S. Gritsky				23B. DATE SIGNED AUG 13 1972			
23C. PHYSICIAN'S NAME (Type) A. S. GRITSKY M.D.				23D. ADDRESS JOHNS HOPKINS HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-17-72		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972		25B. NAME OF REGISTRAR Kelson, F.H.		25C. FUNERAL DIRECTOR V. Bailey		ADDRESS 1348 Calhoun Street	

WYOMING STATE

05-51-14

SADIE CHENG

Y22

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07889

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Otis Gary Parker		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 8 15 72	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 15 72 9:50 p.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 12-15-53		10. AGE (In years last birthday) 18	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Mary Manning & Floyd Parker		ADDRESS 1152 Stricker Street	
19. CAUSE OF DEATH 2965 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Gunshot wound of chest ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 22		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOUSE	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour 8 15 72 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1149 Stricker Street		22F. HOW DID INJURY OCCUR? Subject was shot.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/16/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-21-72	
24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT AUG 18 1972		25B. NAME OF REGISTRAR Sidney L. Horton	
25C. FUNERAL DIRECTOR Kelson F.H.		ADDRESS 1348 Calhoun Street	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07890

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH EVANS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Md. Gen. Hosp.		3. DATE PRONOUNCED DEAD Month Day Year Hour M. 7 21 1972 8:35 p	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Unknown		10. AGE (In years last birthday) 50	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Unknown		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 401	
15. MOTHER'S MAIDEN NAME Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown	
17. SOCIAL SECURITY NO. Unknown		18. INFORMANT ADDRESS Unknown	
19. CAUSE OF DEATH E900X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Heat stroke ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ?	
22C. WHERE DID INJURY OCCUR? ?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 7-21 -72 ? m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Apparent heat stroke during heat wave.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Marvin S. Platt EXAMINER'S NAME (Type) Marvin S. Platt, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) 8-15-72		24B. DATE 8-15-72	
24C. NAME OF CEMETERY or CREMATORY Anatomy Body Inc		24D. LOCATION (City, town, county) Anatomy Body Inc	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972		25B. NAME OF REGISTRAR Diskey, J. H.	
25C. FUNERAL DIRECTOR Raymond J. Curran		25D. ADDRESS Lawson, Ind 21204	

RECEIVED - 10/10/1910

NO.

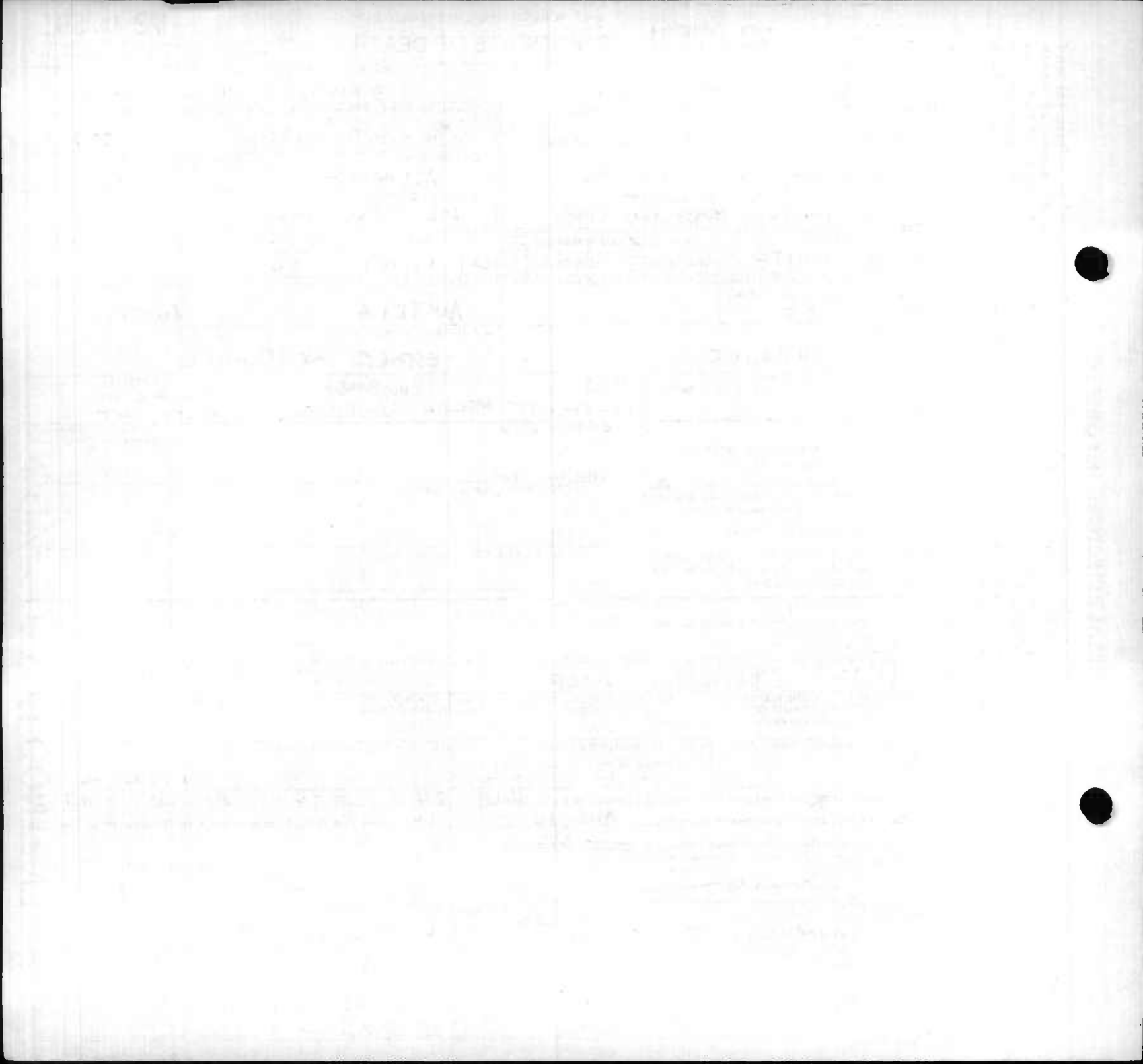
10/10/1910

8-12-15

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-122		72 07891		BALTIMORE CITY HEALTH DEPARTMENT		72 07891	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ETHEL LABKOWSKI				AUG. 15, 1972 12:35 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital or institution, give street address or location)				A. STATE B. COUNTY			
MARYLAND GEN. HOSPITAL 48827 LINDEN AVENUE BALTIMORE, MARYLAND 21201				MARYLAND 21201 401			
5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> FEMALE WHITE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9. AGE (in years lost birthday) OCT. 1, 1907 64			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE				AUSTRIA		AUSTRIA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CANE NEUBAUER				ESTHER NEUBAUER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT (HUSBAND) ADDRESS	
NO				159-01-1095		MELVIN LABKOWSKI 406 PARK AVE. BALTO. MD.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				Myocardial Infarct (?) 1-2 hours			
ANTECEDENT CAUSES				(B) CHF, Premature MI, Myocardial Ischemia years			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) years months			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Diabetes mellitus, Scleritis ulcer years months			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
7/9/72		DECUBITUS ULCER		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (this hospital) attended the deceased from JULY 24 1972 to AUG. 15 1972 that (we) last saw the deceased alive on AUG. 14 1972 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
[Signature]				8/15/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
RAYMOND T. MALLARD MD				827 LINDEN AVE. BALTO. MD. 21201			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. PLACE OF INTERMENT	
		8/16/72		Anatomy Bld.		Anatomy Board of Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		UNIVERSITY MEDICAL SCHOOL	
AUG 18 1972		[Signature]		[Signature]			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Marvin Carmel		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1135 E. Baltimore St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 22 72 11:14 p.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 302			
6. SEX male	7. RACE White	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH UNKNOWN	10. AGE (In years last birthday) 58	E. STREET AND NUMBER 1135 E. Baltimore St.	
11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME UNKNOWN		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN	
15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. UNKNOWN		18. INFORMANT ADDRESS UNKNOWN	
19. CAUSE OF DEATH Undetermined (due to postmortem decomposition) (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/23/72			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE 8-15-72	
24C. NAME OF CEMETERY or CREMATORY Anatomy Body Mt		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972		25B. NAME OF REGISTRAR Sidney Whiston	
25C. FUNERAL DIRECTOR Raymond Curran		ADDRESS Touson, Mo.	

12-13-33

James
Hansbury
Cassidy
Chas. J. Cassidy

Continued from the previous page

WILLIAM
J. HANBURY
JAMES
CASSIDY

8-15-33
JAMES
CASSIDY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72-7893</u> <u>608617</u>
BIRTH NO. <u>72 07893</u>				
1. NAME OF DECEASED (Type or Print) <u>KLEIN PETER, JOHN H.</u>		2. DATE AND HOUR OF DEATH <u>8/16/72</u> <u>11:45 P. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Mid Towne Nursing Home</u> <u>808 ST Paul ST.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>21218</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1315 Lakeside Ave.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/81</u>	9. AGE (in years last birthday) <u>90</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSPECTOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>LUMBER</u>		11. BIRTHPLACE (State or foreign country) <u>EAST BATON ROUGE, LA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>CHARLES F. KLEIN PETER</u>		
14. MOTHER'S MAIDEN NAME <u>CORA AUGOIN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>436-01-5381</u>		17. INFORMANT <u>MRS SOPHIA M. KLEIN PETER (SAME)</u>		
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> <u>Coronary Artery Disease</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Heart Failure</u> (B) Antecedent Causes DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia - Terminal</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 4</u> 19 <u>72</u> to <u>Aug 16</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Aug 14</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>William Appleford</u>		23B. DATE SIGNED <u>8/16/72</u>		23C. PHYSICIAN'S NAME (Type) <u>William Appleford MD</u>
23D. ADDRESS <u>6615 Reisterstown Rd.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>8/19/72</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>	24D. LOCATION (City, town, or county) (State) <u>Parkville, Balto. Co. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 18 1972</u>	25B. NAME OF REGISTRAR <u>John W. Jenkins</u>	25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212</u>		

1. The first part of the paper
is devoted to a general
discussion of the problem
and the methods used in the
investigation.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07894.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07894	
CERTIFICATE OF DEATH					
BIRTH NO. STATE OF MARYLAND-DHMH		1. NAME OF DECEASED (Type or Print) MABEL DONN STEVENS DULIN		2. DATE AND HOUR OF DEATH 8/16/1972 7 30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 209 UPROR ROAD 2712	
5. SEX FEMALE	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-28-08	9. AGE (In years) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME LESTER STEVENS		14. MOTHER'S MAIDEN NAME DONN, MABEL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT JOSEPH HARLAN BLOG	
18. ADDRESS 700 TITLE					
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Artery Disease Diabetes mellitus		6 MTS +			
II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that Dr. H. W. Jenkins (this hospital) attended the deceased from 7/14/72 to 8/18/72 and that Dr. H. W. Jenkins (we) last saw the deceased alive on 8/18/72 and that in Dr. H. W. Jenkins (our) opinion death occurred on the date and hour and from the causes stated above. Dr. H. W. Jenkins (We) (did) (did not) view the body after death.					
23A. SIGNATURE Peter H. Joyce, M.D.		23B. DATE SIGNED 8/18/72		23C. PHYSICIAN'S NAME (Type) PETER H. JOYCE, M.D.	
23D. ADDRESS Union Memorial Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-19-72		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge	
24D. LOCATION Pikesville, Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972		25B. NAME OF REGISTRAR H. W. Jenkins		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.	
ADDRESS 4905 York Road Balto., Md. 21212					

PETER H. JOYCE, D.

W-300 1

BALTIMORE CITY HEALTH DEPARTMENT

72 07895 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07895

BIRTH NO. 72 07895		REG. NO. 72 07895	
1. NAME OF DECEASED (Type or Print) <u>Joseph F. WHITTY</u>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 1442 Cooksie St.</u>		3. DATE PRONOUNCED DEAD Month Day Year Hour <u>8 14 1972 10:45a</u> M.	
6. SEX <u>male</u>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2401</u>	
7. RACE <u>white</u>		C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>1442 Cooksie St.</u>	
9. DATE OF BIRTH <u>2-4-13</u>		10. AGE (In years last birthday) <u>59</u> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>connecticut</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Whitty</u>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>	
15. MOTHER'S MAIDEN NAME <u>Mary McDougall</u>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
17. SOCIAL SECURITY NO. <u>218-10-4130</u>		18. INFORMANT ADDRESS <u>Walter Whitty 1442 Cooksie St.</u>	
19. <u>41214</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic cardiovascular disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <u>8/18/72</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <u>no</u>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Ronald N. Kornblum</u> M.D. DATE SIGNED <u>8-14-72</u> EXAMINER'S NAME (Type) <u>Ronald N. Kornblum, M.D. Deputy Medical Examiner</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/18/72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Holy Cross Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 18 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Johnston</u>	
25C. FUNERAL DIRECTOR <u>Charles L. Stevens Funeral Home, Inc.</u>		ADDRESS <u>1501 E. Fort Avenue</u>	

1940-1941

1940-1941

D-120

BALTIMORE CITY HEALTH DEPARTMENT

72 07896 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07896
REG. NO.

BIRTH NO. STATE OF MARYLAND

1. NAME OF DECEASED (Type or Print) HARRY DAVIS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year August 12, 1972 Estimated <input type="checkbox"/>		3. DATE PRONOUNCED DEAD Month Day Year August 12, 1972 Hour 2:27 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 223 Mt. Holly Street		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2037		6. SEX Male	
7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 12-25-11		10. AGE (In years lost birthday) 61		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTH PLACE (State or foreign country) Randallstown Bldg Co. Md.		12. CITIZEN OF WHAT COUNTRY U.S.		E. STREET AND NUMBER 223 Mt. Holly Street	
13. FATHER'S NAME Harry G. Davis		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		15. MOTHER'S MAIDEN NAME Rachel Wright	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Wise 12137 Benton St	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Marvin S. Platt, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED August 13, 1972	
24A. BURIAL CREMATION, REMARKS (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial 8-16-72		8-16-72		St Thomas Em	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 18 1972		Andrew Whorton		Rayner Sanders 217 E Preston St	

—222

T-1551

BALTIMORE CITY HEALTH DEPARTMENT

72 07897

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07897

BIRTH NO. <u>72 07897</u>		DATE OF BIRTH <u>6/17-23</u>		1. NAME OF DECEASED (Type or Print) LEONA TUBMAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year		3. DATE PRONOUNCED DEAD Month Day Year August 14, 1972		Hour 5:45 P.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL						5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 804					
6. SEX Female		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
9. DATE OF BIRTH 6/17-23		10. AGE (In years lost birthday) 49		11. BIRTHPLACE (State or foreign country) Baltimore		E. STREET AND NUMBER 2231 Prentis Place			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown						14. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Housewife					
15. MOTHER'S MAIDEN NAME Bertina Brown						16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)					
17. SOCIAL SECURITY NO.						18. INFORMANT Harry Tubman					
19. 485X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia and cerebral anoxia						CAUSE OF DEATH Bronchopneumonia and cerebral anoxia					
20. DATE OF OPERATION 22						21. AUTOPSY? (Yes or No) yes					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						22F. HOW DID INJURY OCCUR?					
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.						Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
DATE SIGNED 8/15/72						24A. BURIAL CREMATION, REMOVAL (Specify) Burial					
24B. DATE 8/19/72						24C. NAME OF CEMETERY or CREMATORY St. Calvary Cem. A.A. Co. Md.					
24D. LOCATION (City, town, or county) (State) 217 E. Preston St.						25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972					
25B. NAME OF REGISTRAR Sidney Whorton						25C. FUNERAL DIRECTOR Rayner Sanders					

[Faint, illegible handwriting throughout the page]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 07898	
BIRTH NO. 72 07898					
1. NAME OF DECEASED (Type or Print) <i>Woodrow Dewey Davis</i>			2. DATE AND HOUR OF DEATH <i>8/14/72 - 9:12 p.m. M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>The Union Memorial Hospital</i>			4. USUAL RESIDENCE Where deceased lived. If institution: residence before admission A. STATE <i>Maryland</i> B. COUNTY <i>907</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2635 Garrett Ave</i>		
5. SEX <i>male</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-7-29</i>	9. AGE (In years lost birthday) <i>43</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unemployed</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			13. FATHER'S NAME <i>unknown Dewey Davis Sr.</i>		
14. MOTHER'S MAIDEN NAME <i>unknown Pearl P.</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unknown 5/15/52-10/1954</i>		
16. SOCIAL SECURITY NO. <i>249-44-6047</i>			17. INFORMANT ADDRESS <i>Hospital Record</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonia</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>August 14</i> 19 <i>72</i> to <i>August 14</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>August 14</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>James W. Foster MD</i> DEGREE				23B. DATE SIGNED <i>14 Aug 72</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<i>Shipped</i>		<i>8/18/72</i>		<i>Florence South Carolina</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 18 1972</i>		25B. NAME OF REGISTRAR <i>Anthony Johnston</i>		25C. FUNERAL DIRECTOR <i>Rayner Sanders 217 E. Preston St</i>	

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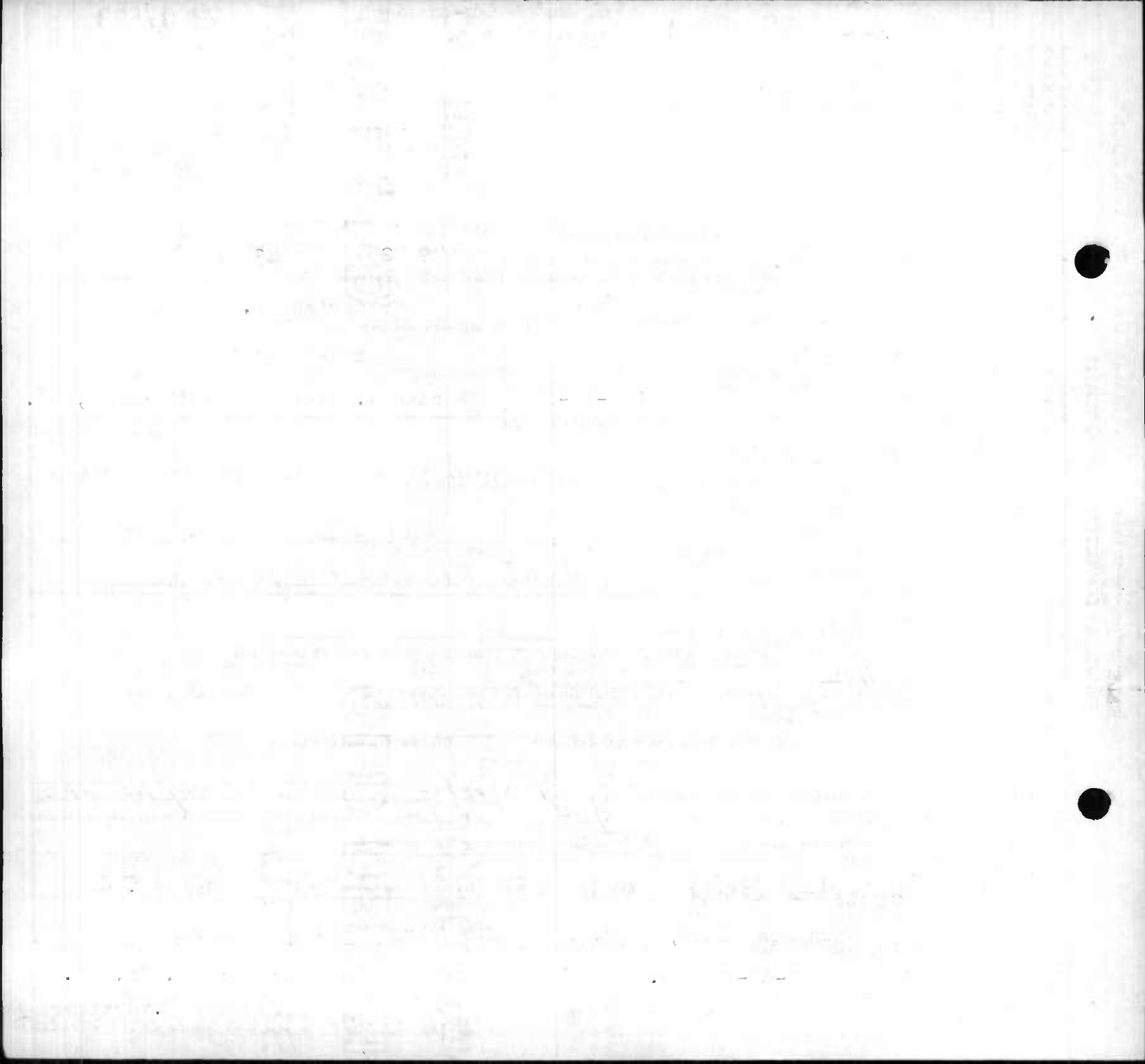
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

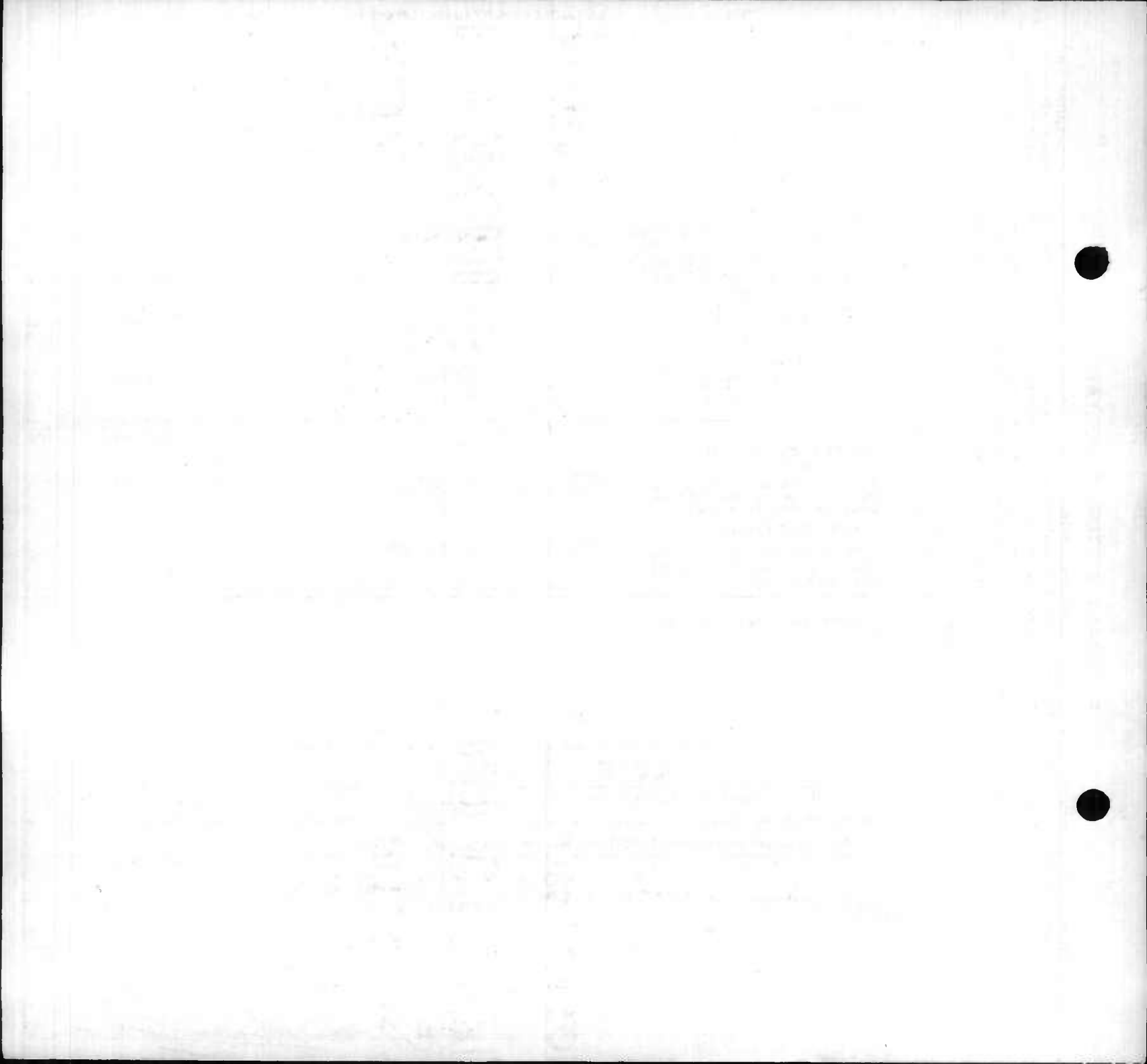
M-100 72 07899		BIRTH NO.		72 07899		REG. NO.		72 07899	
1. NAME OF DECEASED (Type or Print)		PAULINE McHAFFEY		2. DATE AND HOUR OF DEATH		8/14/72		6 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		Maryland		Washington	
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN		D. INSIDE CITY LIMITS?		YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER		Box 20, Rt. 1			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
Female	Cauc.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12/19/28	43	Housewife	Frederick Co.	USA		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Roseoe Lewis		Hattie Lewis		No		218-24-1592		Charles R. Mahaffey Smithsburg, Md. RD1	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Left Ventricular Decompensation		4 hrs.			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		Mitral Valve Disease		10 years.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Acute Rheumatic fever							
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
8/14/72		Mitral stenosis and insufficiency		NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (A) (this hospital) attended the deceased from		8/12/72		19		to		8/14 1972	
that (B) (we) last saw the deceased alive on		8/14		19		72		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (C) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Nicholas Iliff M.D.		8/14/72		Nicholas Iliff, M.D.		The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		8-17-72		Mt. Bethel Methodist		Foxville Fred. Co. Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
AUG 18 1972		Raymond E. Greager		Raymond E. Greager		Thurmont			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07900	
BIRTH NO. 1-220 72 07900				CERTIFICATE OF DEATH	
STATE OF MARYLAND-DEMO					
1. NAME OF DECEASED (Type or Print) MATHILDA W. JUCKES			2. DATE AND HOUR OF DEATH 8-15-72 10:50 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE, MD.			B. COUNTY 905		
			C. CITY OR TOWN BALTIMORE		D. (INSIDE CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3222 ELLERSLIE AVENUE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-18-93	9. AGE (in years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE OWN HOME			10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) NEW YORK
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME HATHUR BUCHMANN UNKNOWN			14. MOTHER'S MAIDEN NAME MATHILDA WEHMEYER UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 218-30-5846		
17. INFORMANT MRS. BENJAMIN SCHILLING UNKNOWN			ADDRESS BEL AIR 3101 N. FRANKLIN ST. BALTIMORE, MD.		
18. 4367 I CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION N.A.		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N.A.		20A. AUTOPSY? (Yes or No) 1	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) N.A.		21B. PLACE OF (INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N.A.		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) N.A.		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> N.A.		21F. HOW DID INJURY OCCUR? N.A.	
22. I certify that (I) (this hospital) attended the deceased from 8-8 19 72 to 8-15 19 72 that (I) (we) last saw the deceased alive on 8-15 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jadashi Kuba				23B. DATE SIGNED 8-15-72	
23C. PHYSICIAN'S NAME (Type) DEGREE				23D. ADDRESS THE UNION MEMORIAL HOSPITAL 33rd and CALVERT ST. BALTIMORE, MD. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/17/72		24C. NAME of CEMETERY or CREMATORY ST. MARY EPISCOPAL	
24D. LOCATION (City, town, or county) (State) ABINGDON ABINGDON MD.		25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972			
25B. NAME OF REGISTRAR Dr. J. H. Kuba		25C. FUNERAL DIRECTOR Edward B. Hansen ADDRESS			



R-521

72 07901

STATE OF MARYLAND
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07901

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CARL L. RAMSBURG		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour August 15, 1972 1:45 A.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Walkersville	
9. DATE OF BIRTH MARCH 18, 1896		10. AGE (In years last birthday) 76 # Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STEINER RAMSBURG		14. MOTHER'S MAIDEN NAME IDA STILL	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BREEDER + TRAINER		16. KIND OF BUSINESS OR INDUSTRY HORSES	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		18. SOCIAL SECURITY NO. 216-14-6972	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Craniocerebral Injuries		20. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
23. DATE OF OPERATION 8/18/72		24. CONDITION FOR WHICH OPERATION WAS PERFORMED	
25. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
27. TIME OF INJURY (APPROX.) 8-14-72 7:30 P. m.		28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rte. 194 - Frederick County		30. HOW DID INJURY OCCUR? Fell from moving truck	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 8/15/72			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/18/72	
24C. NAME OF CEMETERY or CREMATORY MT OLIVET		24D. LOCATION (City, town, or county) (State) FREDERICK FRED, MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972		25B. NAME OF REGISTRAR Adrian H. Hinton	
25C. FUNERAL DIRECTOR BARTON FUNERAL HOME, WALKERSVILLE, MD.		25D. ADDRESS	

MAILED
U.S.A.
STEVEN RAMBERG
IDA STALL
BRITISH TRAVEL

BRITISH TRAVEL
21/12
MT OLIVET
FREDERICK, TEX, MD
BARTON LANE, HOME WALKING

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-450		72 07902		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 07902	
1. NAME OF DECEASED (Type or Print) Betty Lee Allen				2. DATE AND HOUR OF DEATH 8/14/72 8:15 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Howard C. CITY OR TOWN Ellicott City D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2817 Pinewick Rd.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-22-1928	9. AGE (In years last birthday) 44	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical		10B. KIND OF BUSINESS OR INDUSTRY C+P Telephone		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ferdinand H. Engel				14. MOTHER'S M maiden NAME Ethel Graves			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-26-0352		17. INFORMANT Edward Allen ADDRESS 2817 Pinewick Rd, Ellicott City, Md 21043			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I Pulmonary Metastases - (A) IMMEDIATE CAUSE Due to, or as a consequence of: Carcinoma of the Breast II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 8/14/72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Removal of Breast 20A. AUTOPSY? (Yes or No) <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 hr. 8 hr.			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 1972 to August 14 1972 that (I) (we) last saw the deceased alive on August 2 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE George J. Richards Jr.				23B. DATE SIGNED 8/15/72			
23C. PHYSICIAN'S NAME (Type) George J. Richards Jr.				23D. ADDRESS 6701 N. Charles St 21204			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/72		24C. NAME OF CEMETERY or CREMATORY Lorraine Cemetery		24D. LOCATION (City, town, or county) (State) Dogwood Rd. Woodlawn Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972		25B. NAME OF REGISTRAR Sidney W. ...		25C. FUNERAL DIRECTOR SLACK F. A.		ADDRESS Ellicott City, Md. 21043	

Female white

General

Ferdinand H. Engel

No

G+P Telephone

Wanyland

ETel

Graves

242-2222 Edward Miller

3-22-228 44

EXIT Telephone 104
Elliot City
718

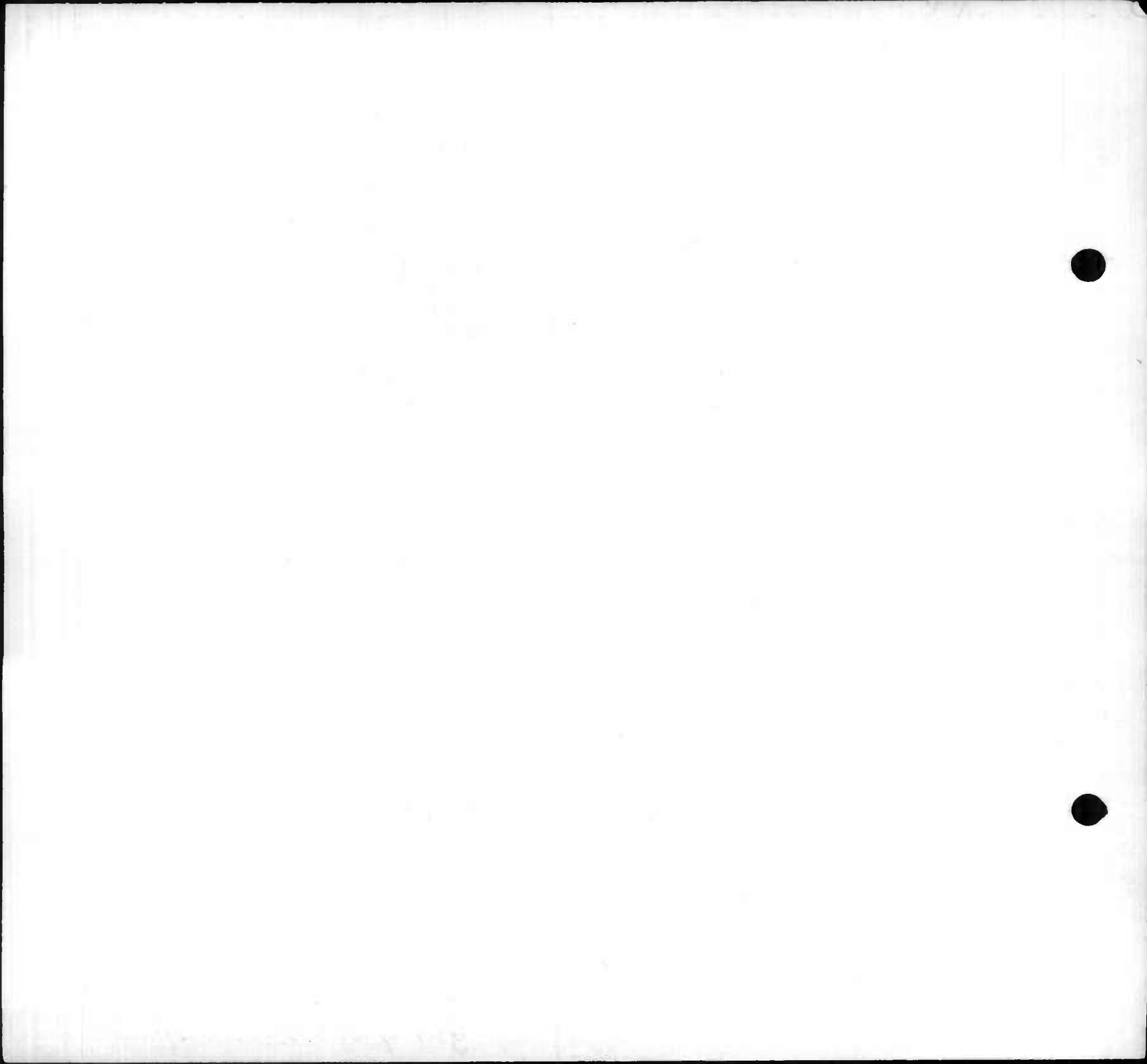
EXIT City 104
3-22-228

STATE OF MARYLAND - DEMH BALTIMORE CITY HEALTH DEPARTMENT									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
REG. NO. 72 07903									
BIRTH NO. <u>M-324</u>									
1. NAME OF DECEASED (Type or Print) <u>ROSEMARY A. MITCHELL</u>									
2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <u>8-13-72</u> M.									
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 University Hospital</u>									
3. DATE PRONOUNCED DEAD Month Day Year Hour <u>8</u> <u>13</u> <u>1972</u> <u>2:55</u> P. M.									
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Del.</u> B. COUNTY <u>Cecil</u> C. CITY OR TOWN <u>Newark</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
6. SEX <u>female</u> 7. RACE <u>white</u> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
9. DATE OF BIRTH <u>10-8-1954</u> 10. AGE (In years last birthday) <u>17</u> 11. BIRTHPLACE (State or foreign country) <u>Pittston, Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>William H. Mitchell</u> 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> 15. MOTHER'S MAIDEN NAME <u>Rosemary A. Mitchell</u>									
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> 17. SOCIAL SECURITY NO. <u>213-58-1823</u> 18. INFORMANT <u>Matthew C. Mitchell</u> ADDRESS <u>Same</u>									
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
20A. DATE OF OPERATION <u>8-13-72</u> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Multiple injuries</u> 21. AUTOPSY? (Yes or No) <u>no</u>									
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>highway</u> 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <u>Rt. 273 1 1/2 mi. east Rt. 280 Cecil Co.</u>									
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>8-13-72</u> <u>12:25</u> P.M. 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 22F. HOW DID INJURY OCCUR? <u>Passenger in car which struck a guard-rail, turned over, throwing subj. out.</u>									
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Russell S. Fisher</u> M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8-14-72</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>8-17-72</u> 24C. NAME OF CEMETERY or CREMATORY <u>All Saints</u> 24D. LOCATION (City, town, or county) (State) <u>Kirkwood Hwy, Wilm. Dela.</u>									
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 18 1972</u> 25B. NAME OF REGISTRAR <u>Adrian W. Winton</u> 25C. FUNERAL DIRECTOR <u>James J. Warwick</u> ADDRESS <u>Newark, Del.</u>									

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07904		REG. NO. 72 07904	
N-200				72 07904		STATE OF MARYLAND-DEMH	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) NOCK, Henry				2. DATE AND HOUR OF DEATH 8/16/72 6:10 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) GOOD Samaritan Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 907			
5. SEX M				6. RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY None		8. DATE OF BIRTH 1/3/94	
13. FATHER'S NAME Henry Knox Sr.				14. MOTHER'S MAIDEN NAME Janie Bailey		9. AGE (In years last birthday) 78	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII				16. SOCIAL SECURITY NO. 218-03-6874		11. BIRTHPLACE (State or foreign country) Virginia	
17. INFORMANT Bessie Nock				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma of Esophagus 4 mos. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos.			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 31 1972 to August 16 1972 that (I) (we) last saw the deceased alive on 5:00 Am Aug 16 1972 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dennis Brett				23B. DATE SIGNED 8/16/72		23C. PHYSICIAN'S NAME (Type) Dennis Brett	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8-19-72		24C. NAME OF CEMETERY or CREMATORY MT. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.				25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972			
25B. NAME OF REGISTRAR Sidney H. Hinton				25C. FUNERAL DIRECTOR Elmer G. Wilson 1000 Brimley Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07905		72 07905	
C-235				72 07905		72 07905	
BIRTH NO.				72 07905		72 07905	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Ruben Eleon Coston				8/14/72 3 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				A. STATE B. COUNTY			
University of Maryland 38				Maryland 1604			
5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9. AGE (In years last birthday) 10. Under 1 Yr. 11. Under 24 Hrs.			
Female Colored				2-27-1906 66 Months Days Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Housewife				Kent Island, Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Roderick B. Brown				Roxie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				Edward R. Coston			
18. CAUSE OF DEATH				ADDRESS			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Myocardial Infarction 5 days			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Atherosclerotic Cardiovascular disease Years			
II				(C) Diabetes mellitus Years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Acute Renal failure 20 to 5 days			
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				8/10/72 Peritoneal Bypass			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21D. TIME OF INJURY (APPROX.) 21E. INJURY OCCURRED				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8/1 1972 to 8/14 1972				21F. HOW DID INJURY OCCUR?			
that (I) (we) last saw the deceased alive on 8/14 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE 23B. DATE SIGNED			
Louis E. Grenzer				8/14/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Louis E. Grenzer				1604			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				8-19-72			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Arbutus Mem. Park				Arbutus Md.			
25A. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
Audrey [unclear]				Gloria O. Wilson 1604 Brimley Ave.			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07906

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ESAIAS J. BOONE				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 8 13 1972 9:56 p M.			
6. SEX male				7. RACE negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Sept. 20, 1947				10. AGE (In years last birthday) 24		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Herman Boone		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2798	
15. MOTHER'S MAIDEN NAME Marie M. Bishop				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
17. SOCIAL SECURITY NO.				18. INFORMANT ADDRESS Marie M. Boone Same			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Stabwound of chest and heart ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 8-13-72				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes							
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) bar			
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 328 S. Bentalou St. 2005				22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 8-13-72 9:30 p m.			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Stabbed during argument.			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-14-72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-17-72		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 18 1972		25B. NAME OF REGISTRAR A. J. Wilson		25C. FUNERAL DIRECTOR ADDRESS E. J. Wilson 1000 Brantley Ave Balto. Md. 21217			

10-1508

10-1508

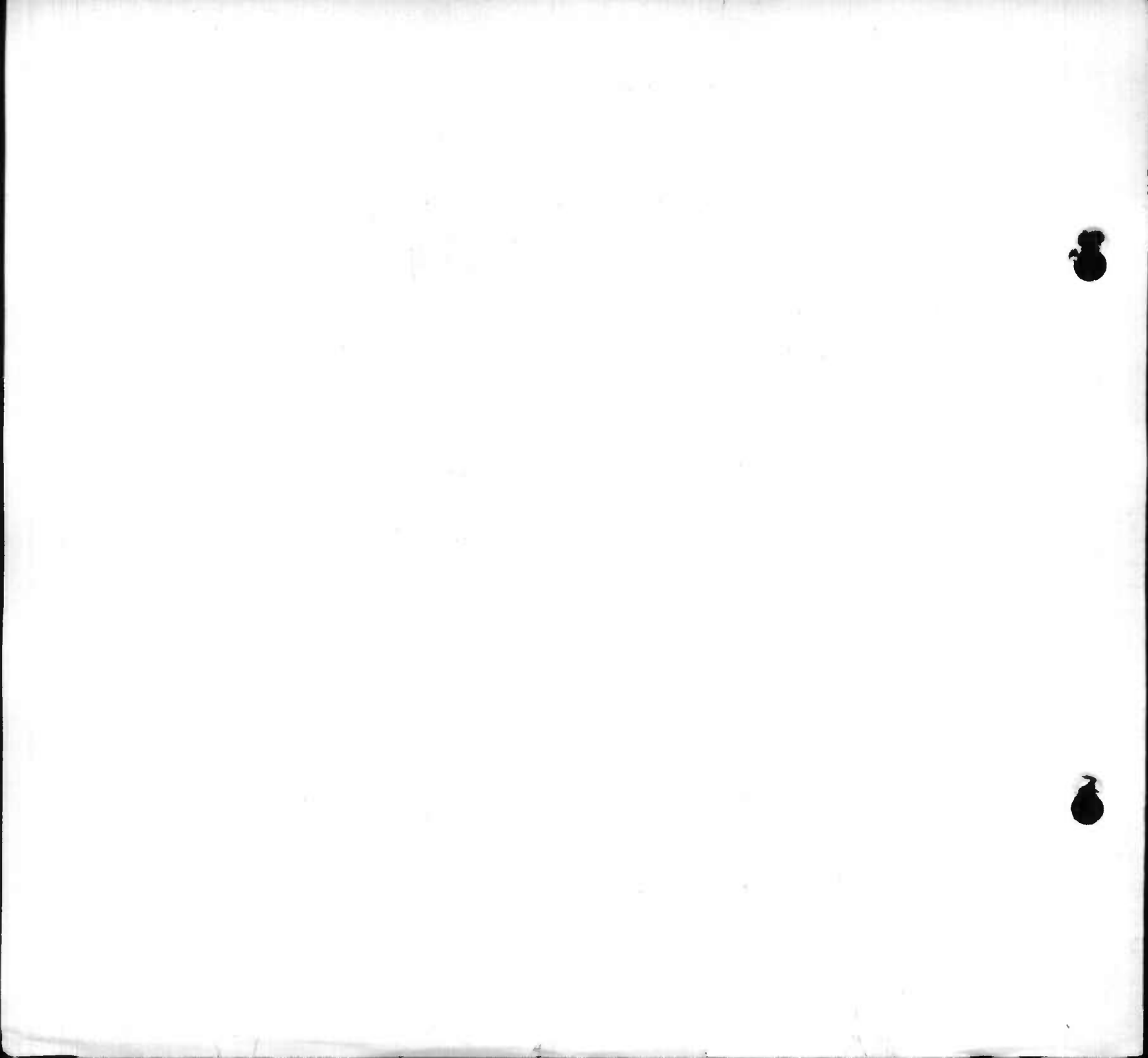
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

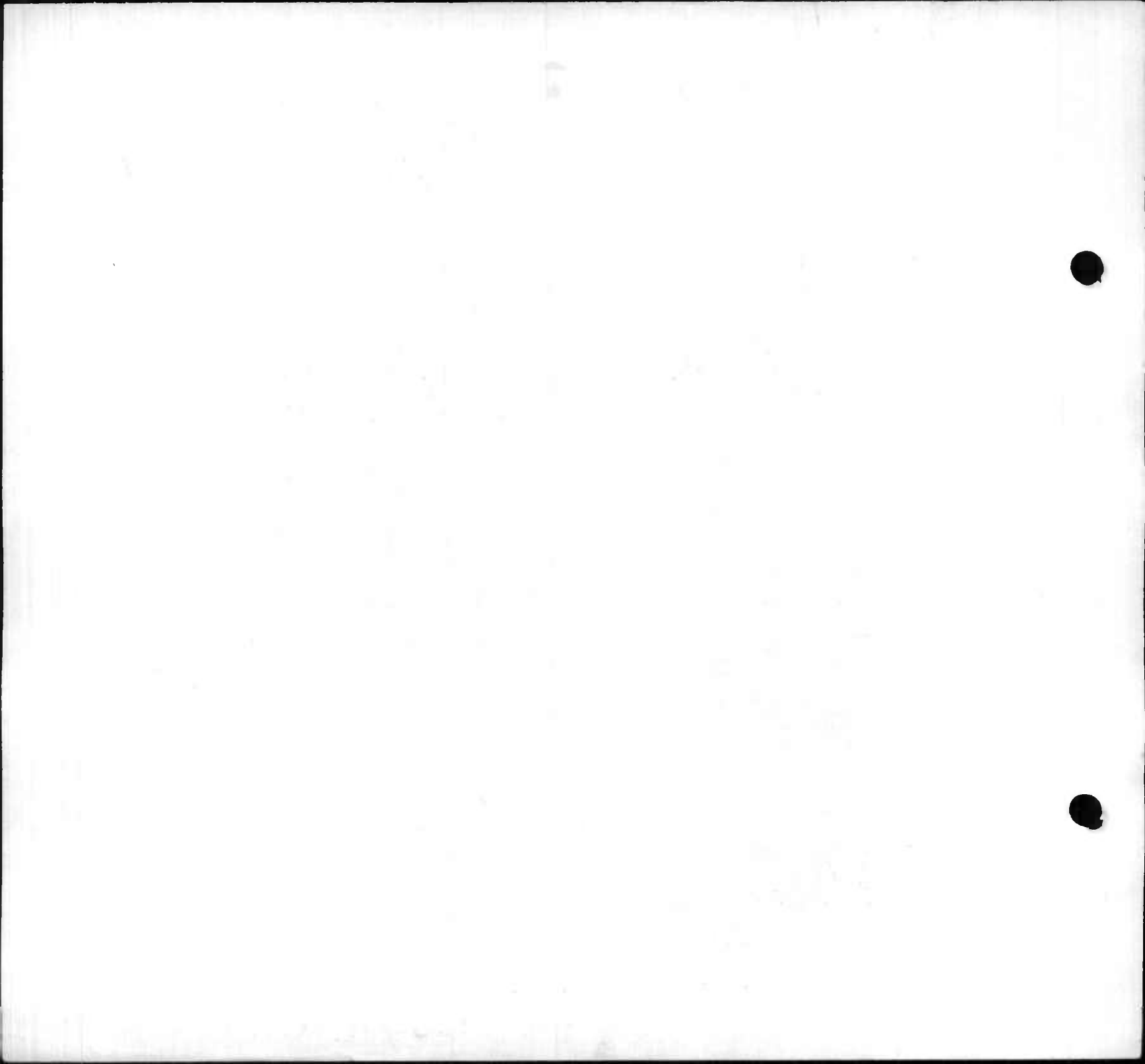
BALTIMORE CITY HEALTH DEPARTMENT				72 07907		REG. NO. 72 07907	
H-630				72 11707		STATE OF MARYLAND-DHMH	
BIRTH NO. 72-11707				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>holley gail HART</i>				2. DATE AND HOUR OF DEATH <i>Aug. 16, 72 9 14 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Lutheran Hosp. of Maryland</i>				A. STATE <i>MD</i> B. COUNTY <i>2710</i>			
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>929 E. 43rd ST.</i>			
5. SEX <i>female</i>	6. RACE <i>black</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/14/72</i>		9. AGE (in years last birthday) <i>24y</i>	10. Under 1 Yr. Months <i>02</i>	11. Under 24 Hrs. Hours <i>02</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>BAL. MD</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13. FATHER'S NAME <i>unknown</i>				14. MOTHER'S MAIDEN NAME <i>LINDA HART</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Chart</i>		ADDRESS	
18. CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		<i>Interventricular hemorrhage 24hs</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>Prematurity</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>55hs</i>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Aug 15</i> 19 <i>72</i> to <i>Aug 16</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>Aug 16</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Sang Y. Rhim, MD</i>				23B. DATE SIGNED <i>8/16/72</i>		23C. PHYSICIAN'S NAME (Type) <i>SANG Y. RHIM, MD</i>	
23D. ADDRESS <i>Lutheran Hosp. of Maryland</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-18-72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>MT. Calvary Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Brooklyn MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 18 1972</i>		25B. NAME OF REGISTRAR <i>Anthony Whitton</i>		25C. FUNERAL DIRECTOR <i>Elmer D. Wilson</i>		ADDRESS <i>100+ Brantley Ave.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-600		72 07908		BALTIMORE CITY HEALTH DEPARTMENT		72 07908	
BIRTH NO.		72 07908		CERTIFICATE OF DEATH		STATE OF MARYLAND	
1. NAME OF DECEASED (Type or Print)		HAZEL MURRAY		2. DATE AND HOUR OF DEATH		8/15/72 1:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MD		BALTO.	
UNIVERSITY HOSPITAL				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER		1225 MYRTLE AVE.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	
F	N	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	3-5-00	72			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		None		WASHINGTON, D.C.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Henry Howell		Susie Sparlock		No		220-70-6871	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Erma Sullivan				I		24 hrs	
				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
				(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
				ANTECEDENT CAUSES			
				DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
				(A) IMMEDIATE CAUSE PROBABLE GRAM \ominus SEPSIS		24 hrs	
				DUE TO, OR AS A CONSEQUENCE OF:			
				(B) URINARY TRACT INF.		24 hrs	
				DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
				II			
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Left Lung Mass - Dx Unknown	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from		8/19/72		19		to 8/15 1972	
that (I) (we) last saw the deceased alive on		8/15		1972		and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Mark H. Kasowitz		8/15/72		MARK H. KASOWITZ		UNIVERSITY HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-21-72		MT. Auburn Cem.		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 18 1972		Edna Wilson		Edna Wilson		1000 Brattleway Ave Baltimore Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Alma Oliver Ebron

2. DATE AND HOUR OF DEATH

August 17, 1972

5:35 P M.

REG. NO.

72 07909

STATE OF MARYLAND-DHMH

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Ave.

Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1735 McCulloh St. 21217 007

5. SEX

Female

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

2/21/39

9. AGE (In years
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

William F. Moore

14. MOTHER'S MAIDEN NAME

Lundy

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT 4940 Eastern Ave. ADDRESS

BCH Records: Baltimore, Md. 21224

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxiation, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE POST-OP BLEEDING
DUE TO, OR AS A CONSEQUENCE OF:
HEART FAILURE(B) ANGPHERIC STATE
DUE TO, OR AS A CONSEQUENCE OF:

(C) CHRONIC RENAL FAILURE

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

8/17, 8/16

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

ANGPHERIC

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/14 19 72 to 8/17 19 72
that (I) (we) first saw the deceased alive on 8/17 72 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Roy A. Meals MD

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

8/17/72

23C. PHYSICIAN'S
NAME (Type)

ROY A. MEALS

23D. ADDRESS

4940 Eastern Ave. Baltimore, Md.
BALT. CITY HOSP24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

8/21/72

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

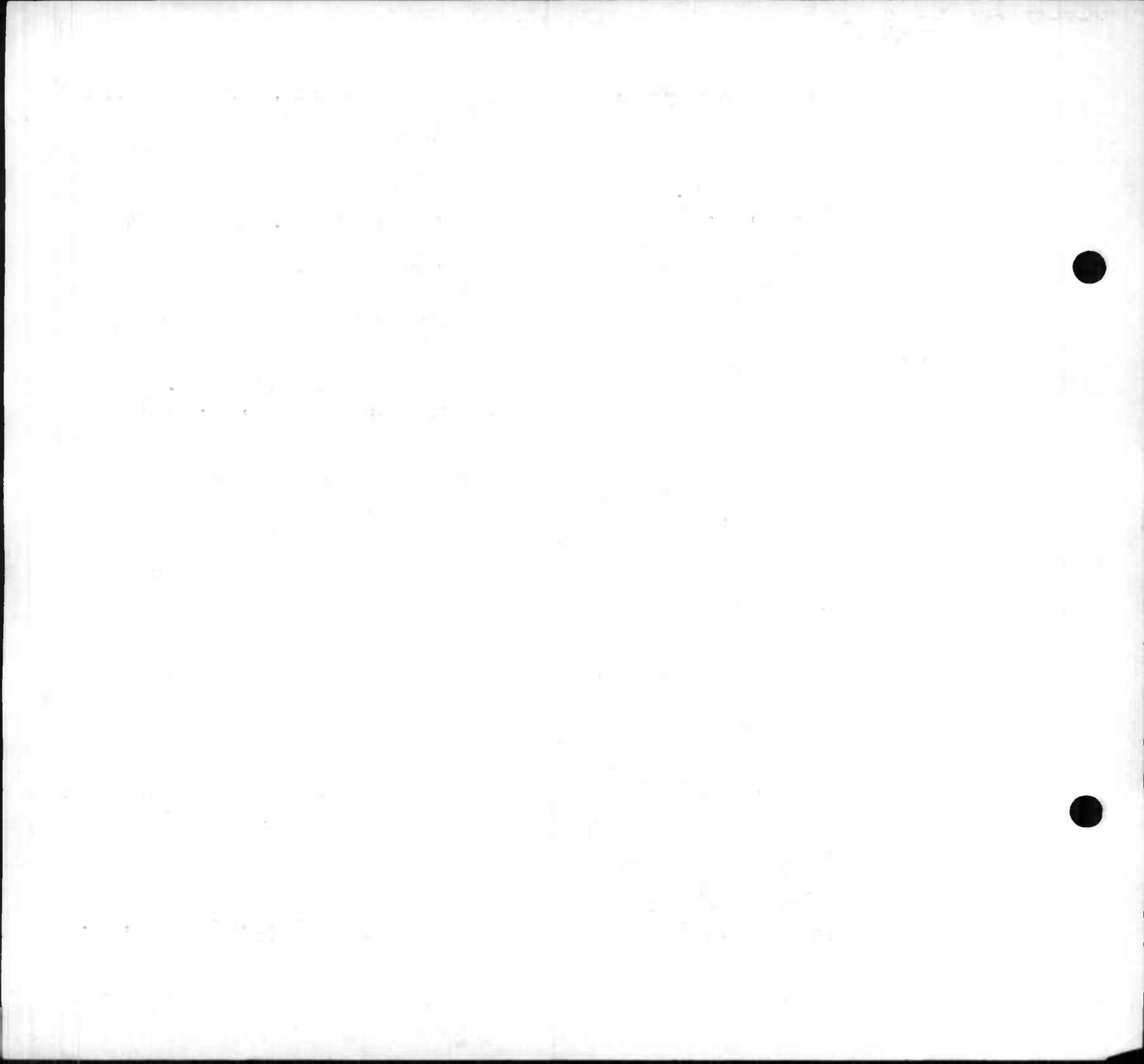
25A. DATE REC'D BY HEALTH DEPT.

AUG 21 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Chase City, Virginia
172 W. North Ave



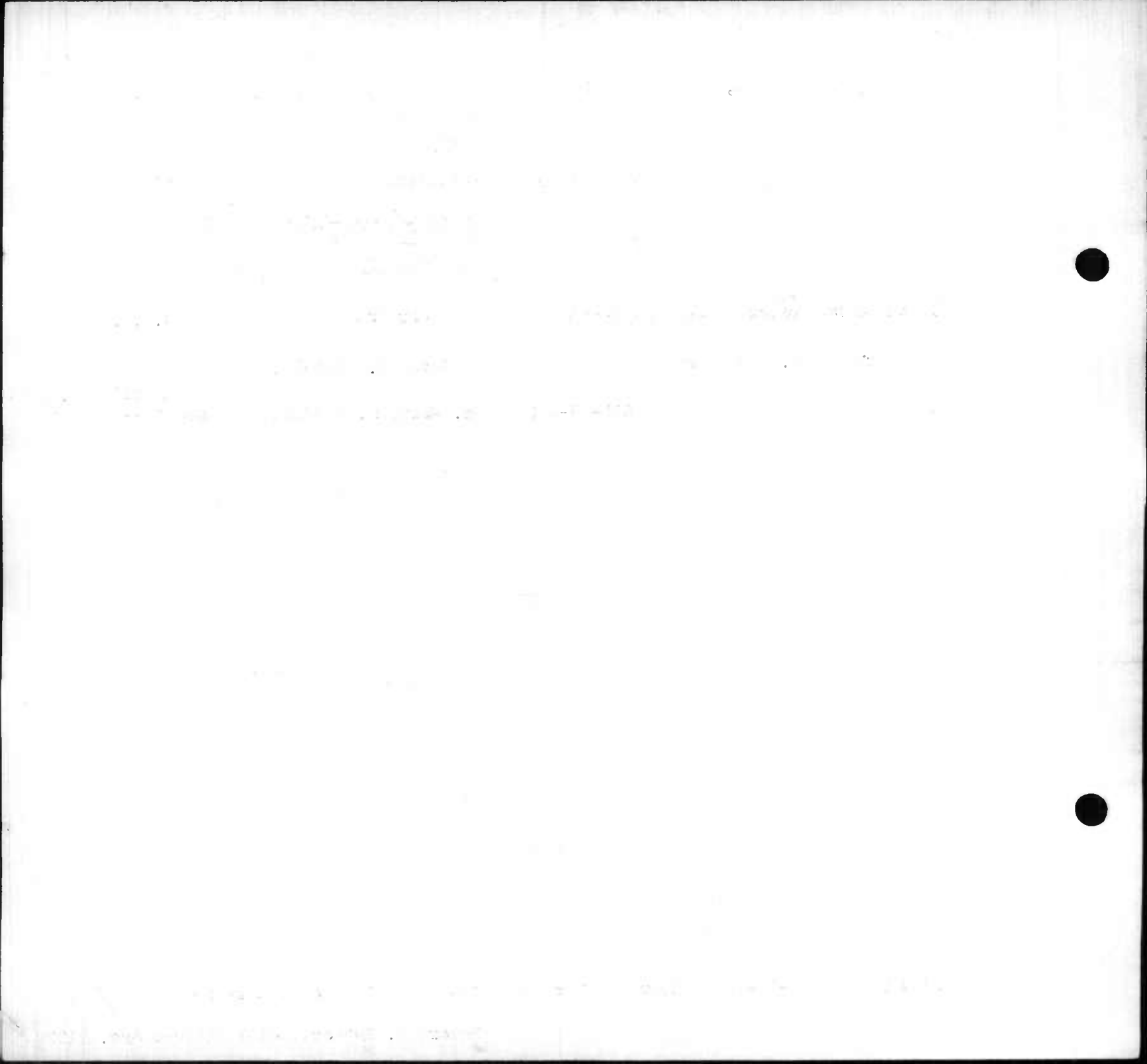
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-355 72 07910

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 07910
STATE OF MARYLAND, DUMFRIES

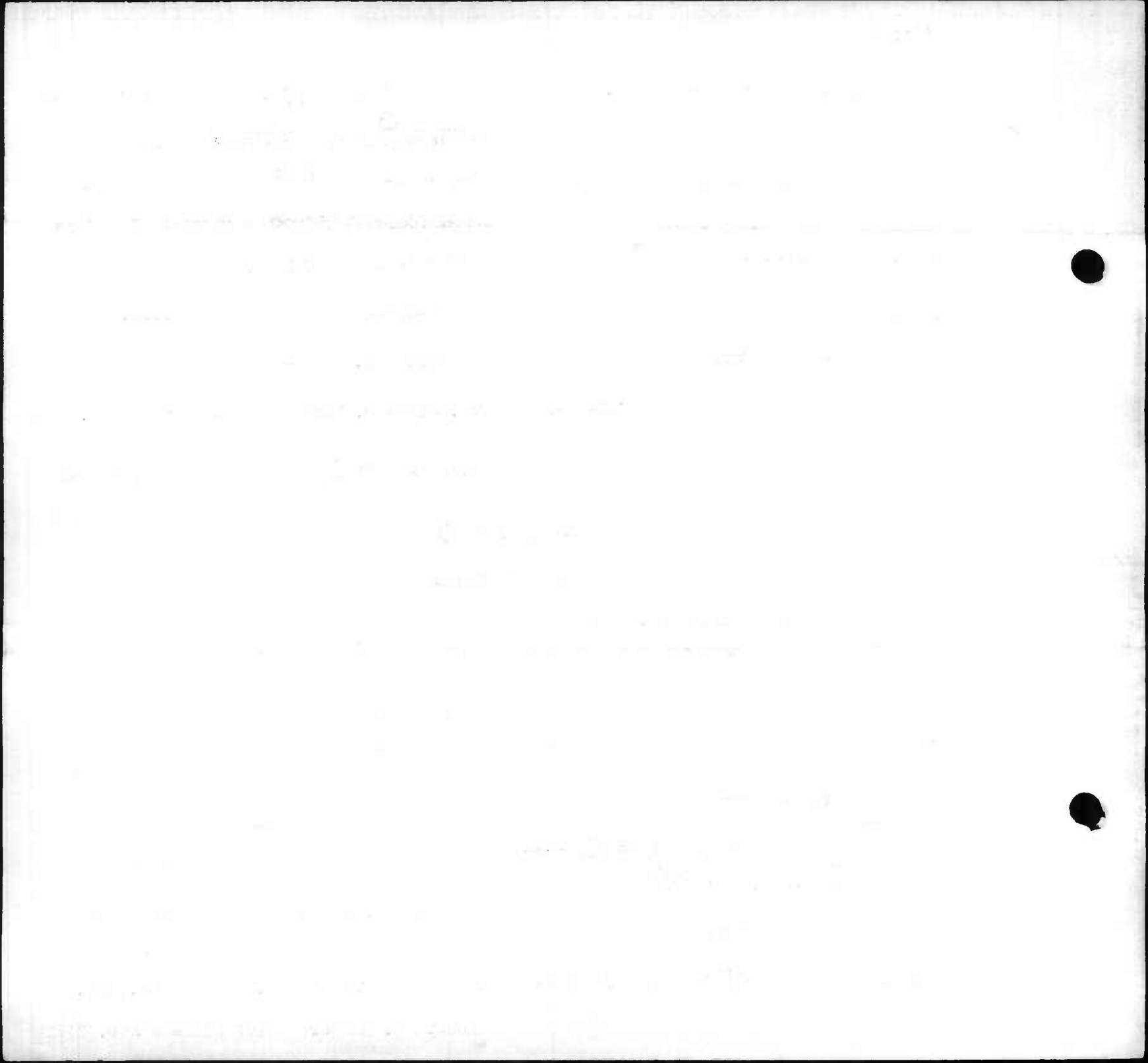
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>GOODMAN, HARRY Z</u>		2. DATE AND HOUR OF DEATH <u>8-14-72 16-50 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital of Maryland</u> <u>46</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2002</u>	
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		8. DATE OF BIRTH <u>11-27-02</u>	
13. FATHER'S NAME <u>Harry H. Goodman</u>		14. MOTHER'S MAIDEN NAME <u>Rosa E. Zeigler</u>		9. AGE (In years last birthday) <u>69</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-07-4225</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infection</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		17. INFORMANT <u>Mr. Harry A. Goodman, 344 Cecilton South.</u>	
19A. DATE OF OPERATION <u>8-9-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-9-1972</u> to <u>8-14-1972</u> that (I) (we) last saw the deceased alive on <u>8-14-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Shaf Siddiqi MD</u>		23B. DATE SIGNED <u>8-14-72</u>		23C. PHYSICIAN'S NAME (Type) <u>JAWED H. SIDDIQI MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-18-1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>21 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Hubbard</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	
24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

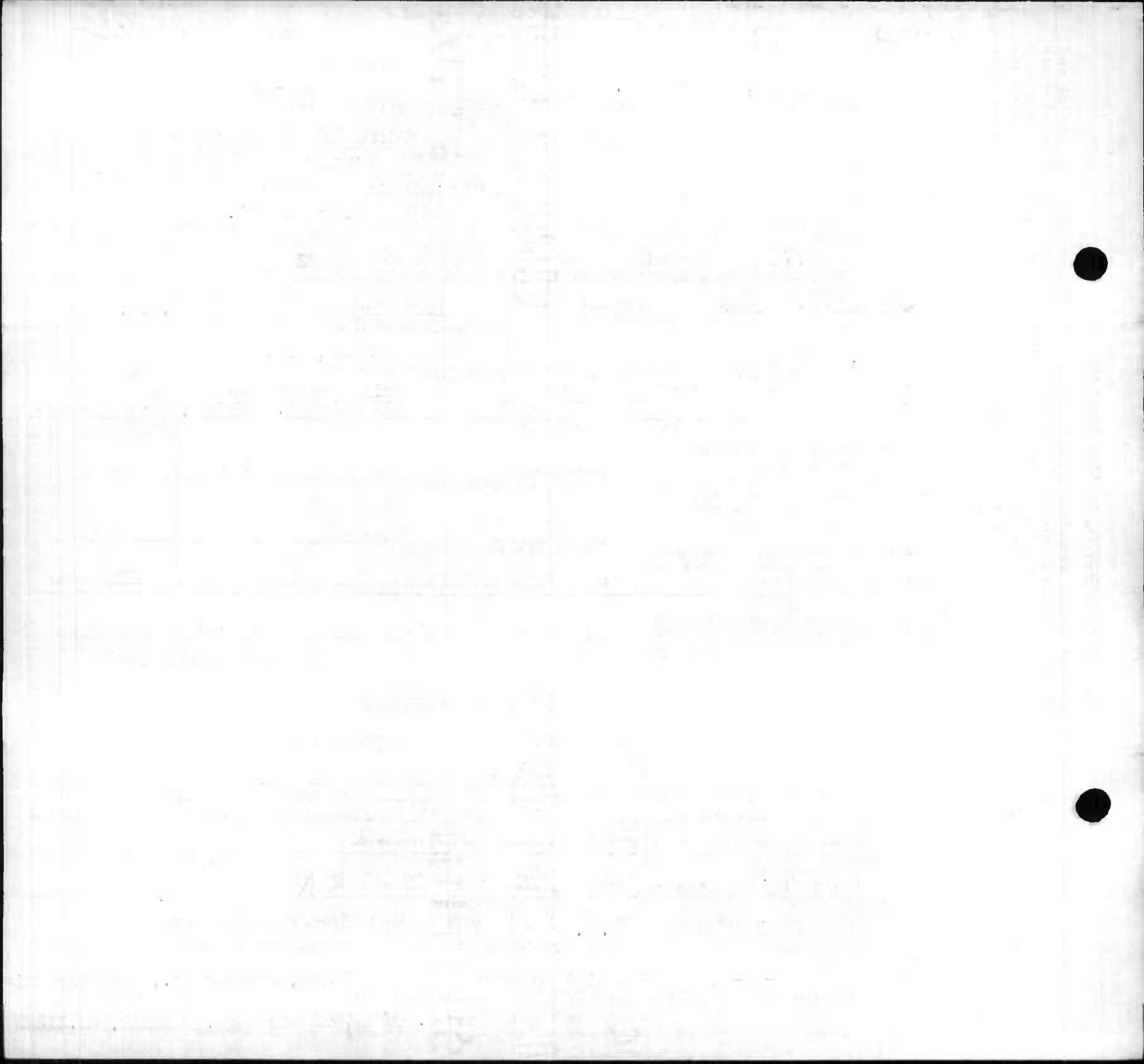
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 07911 STATE OF MARYLAND-DEMH	
BIRTH NO. 17-620		72 07911			
1. NAME OF DECEASED (Type or Print) MARSH, FILBERT H.			2. DATE AND HOUR OF DEATH Aug. 16, 1972 6:45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GEN'L HOSPITAL 43			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE Highlands D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3714 Annapolis Road 21227		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/11/1902	9. AGE (In years last birthday) 70	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME William Marsh			14. MOTHER'S MAIDEN NAME Edith C. Kyser		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-09-6939		
			17. INFORMANT Mrs. Alice G. Marsh, 3714 Annapolis Rd. 21227		
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE M.I. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. A.S.C.V.D. GMPHYSEMA			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 19 to 19 that (1) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE M. Kovacevic			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) KOVACEVIC
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 8-19-1972		24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972			25B. NAME OF REGISTRAR Sydney Hubbard		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

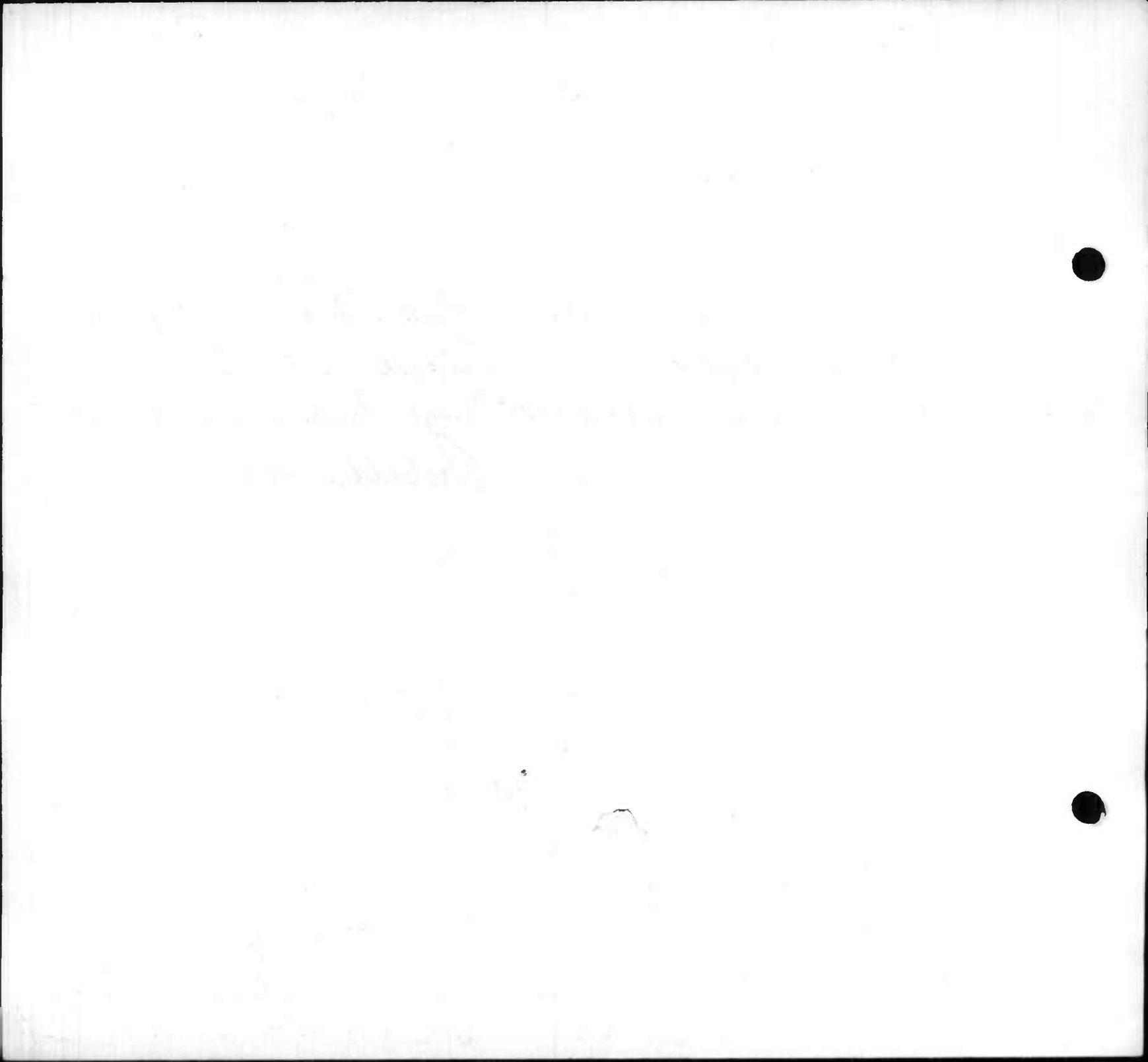
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72-7912</u>	
BIRTH NO. <u>H-400</u> <u>72 07912</u>				STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
HALL, JACKSON I.			8/18-72 1907 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
JOHNS HOPKINS HOSPITAL			MARYLAND Baltimore		
5. SEX			6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
MALE			WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH			9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10/08/89			82		Construction & Farmer
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME
West Virginia			U.S.A.		HALL, ABEL
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
LYONS, ALICE			No		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
233 22 9411			Vail Funeral Home 512 Main St. Ripley, West Virginia		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Cardiopulmonary collapse 36 hours		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Myocardial Ischemia 12 hours		
(C) Dehydration 48 hours			(D) Military tuberculosis, Osteomyelitis 3-5 yrs		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
Yes			Yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			22. I certify that (I) (this hospital) attended the deceased from 8/17 19 12 to 8/18 19 12		
23A. SIGNATURE			23B. DATE SIGNED		
Kenneth Baughman M.D.			8/18/72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
KENNETH BAUGHMAN M.D.			THE JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		
Burial			8-22-72		
24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Pine Hill Cemetery			Ripley, Jackson Co., West Virginia		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		
AUG 21 1972			John J. Duda		
25C. FUNERAL DIRECTOR ADDRESS			25D. DATE OF DEATH		
John J. Duda 7922 Wise Ave. Dundalk, Md. 21222			8/18/72		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-400		72 07913		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07913	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Albert L. Poole, SR.</u>		2. DATE AND HOUR OF DEATH <u>8/18/72</u> <u>2:30 P.M.</u>		STATE OF MARYLAND-DHMH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Balto</u>		C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>1044 Lombard St.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-13-33</u>	9. AGE in years last birthday <u>39</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Printing Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Norman Poole</u>		14. MOTHER'S MAIDEN NAME <u>Hazel Stultz</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>Yes</u> <u>Corporal</u> <u>Mar</u> <u>26-28-6985</u>		16. SOCIAL SECURITY NO. <u>26-28-6985</u>	
17. INFORMANT <u>Tracy E. Poole</u>		ADDRESS <u>1044 W. Lombard St.</u>		18. CAUSE OF DEATH <u>Probable M.I.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Probable M.I.</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u></u>	
(C) <u></u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>		19A. DATE OF OPERATION <u>8/18/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>	
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <u>8/18/72</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u></u>	
22. I certify that (I) (this hospital) attended the deceased from <u>8/16/72</u> to <u>8/18/72</u> and that (I) (we) last saw the deceased alive on <u>8/18/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.		23A. SIGNATURE <u>Mark H. Kasow</u>		23B. DATE SIGNED <u>8/18/72</u>		23C. PHYSICIAN'S NAME (Type) <u>MARK H. KASOW MD</u>	
23D. ADDRESS <u>University Hosp</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>8/22/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Glen Haven Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Glenburnie, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 21 1972</u>		25B. NAME OF REGISTRAR <u>John J. Casan</u>		25C. FUNERAL DIRECTOR <u>John J. Casan</u>	
25D. ADDRESS <u>1044 W. Lombard St.</u>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07914	
L-260 72 07914				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Leser William G.		Aug. 16, 1972 6:00 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
South Baltimore General Hosp.				Maryland, D.C. 2102	
43				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX 6. RACE 7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				E. STREET AND NUMBER	
M. White				1253 James St.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 9. AGE (In years last birthday)	
Salesman		Storm Window Co.		2/9/99 73	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
Maryland				U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
? (dec)				? (dec)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		214-03-1262		Bernard E. Huston Jr. 1222 Sargent St.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
				Right lower lobe pneumonia	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Abnormal fibrillation	
				(C) Acute myeloblastic leukemia	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-12 1972 to 8-16 1972 that (I) (we) last saw the deceased alive on 8-16 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Hee Mar Gray				Aug 16, 72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				South Baltimore General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
burial		8/21/72		Leser Hill Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 21 1972		Dudley W. Horton		J. J. Conner, Jr. 901 Hollins St. Balt. Md.	

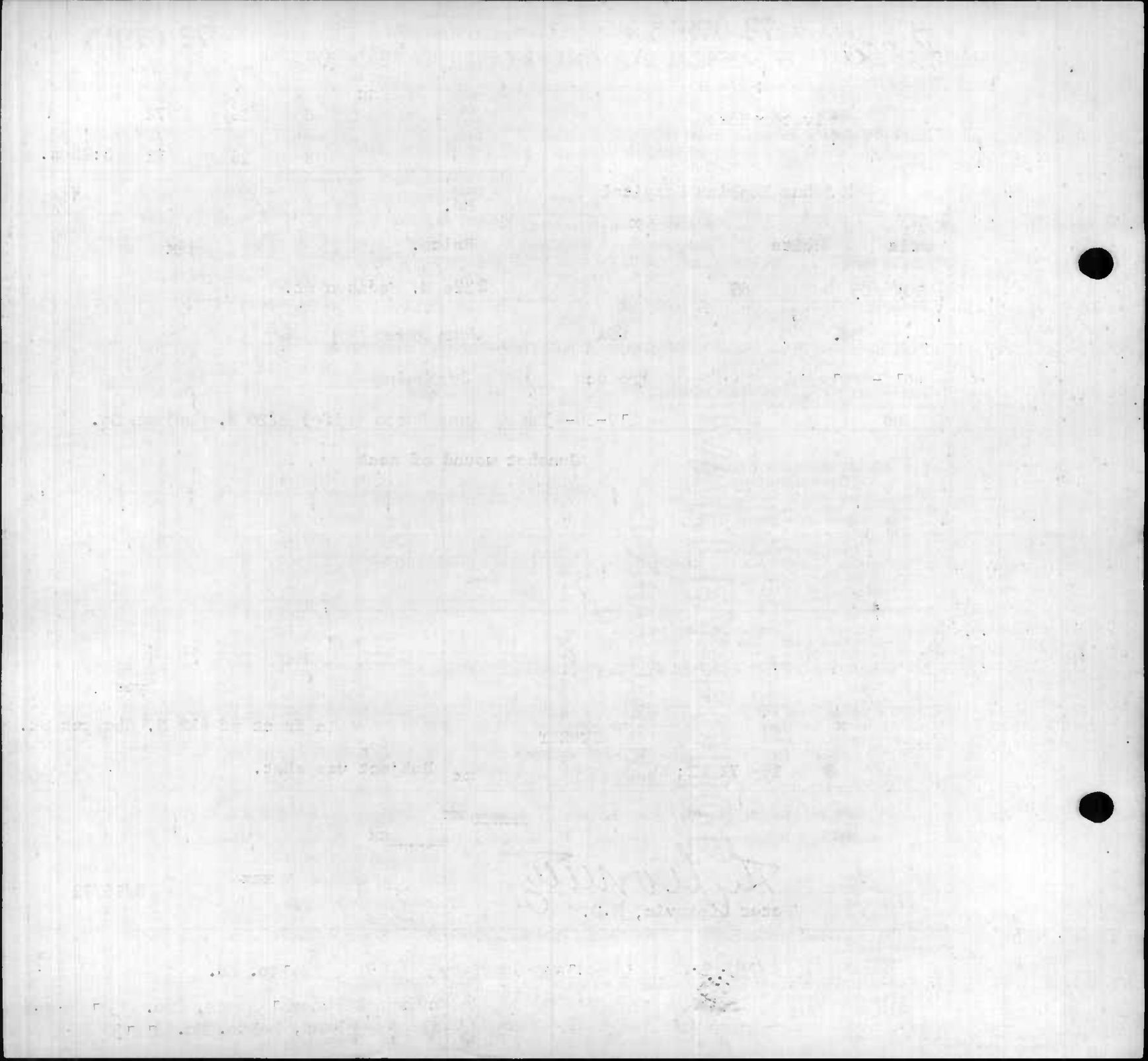
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07915

BIRTH NO.

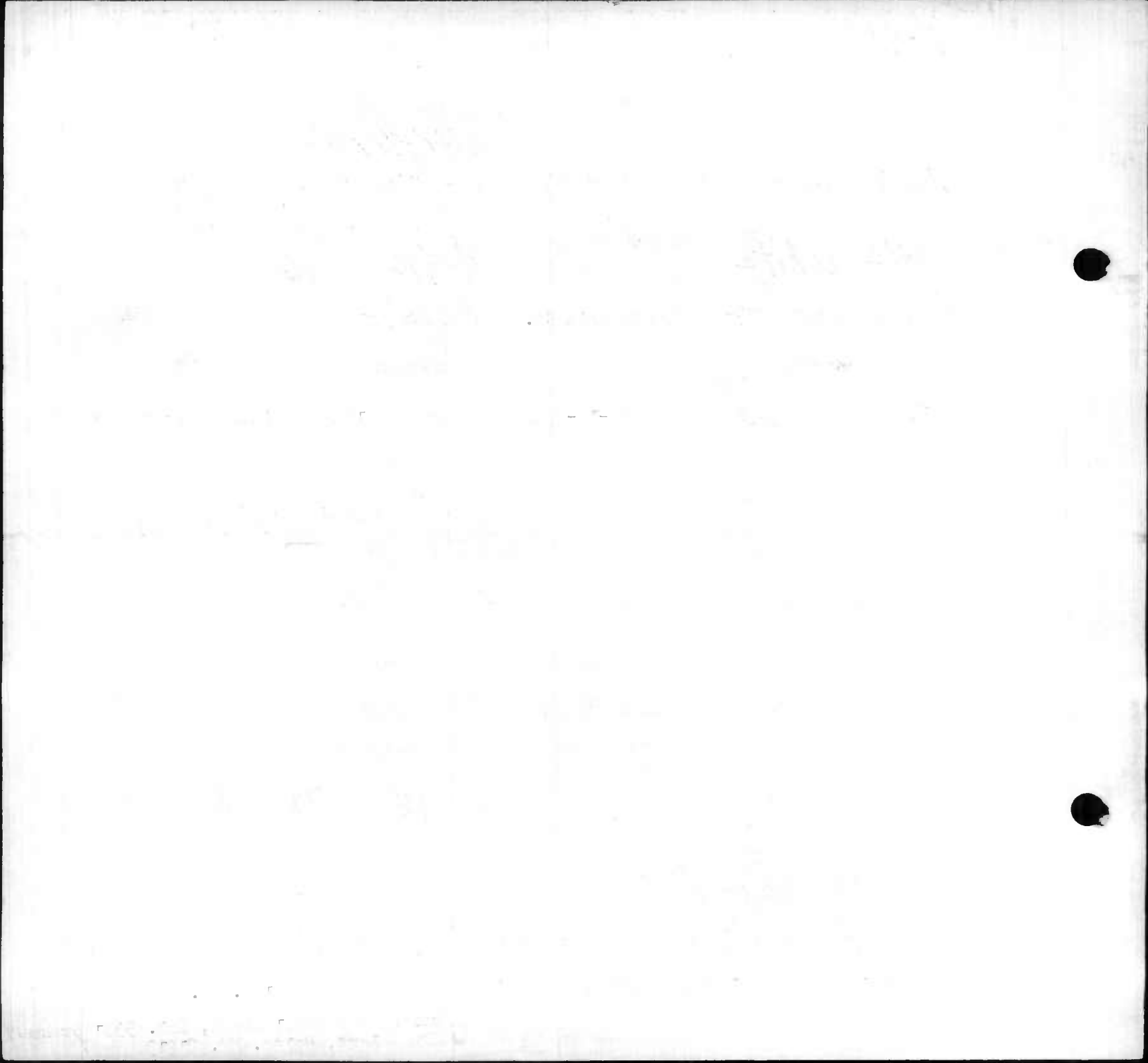
REG. NO.

1. NAME OF DECEASED (Type or Print) Salvatore Russo				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 8 16 72			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 8 16 72 3:25 a.			
6. SEX male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 10/6/05				10. AGE (In years last birthday) 66		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John Russo		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) self-employed	
15. MOTHER'S MAIDEN NAME Josephine				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 279-30-8344	
18. INFORMANT Anna Russo (wife)				19. ADDRESS 2226 E. Madison St.			
19. CAUSE OF DEATH Gunshot wound of neck				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? In front of 612 N. Chester St.				22D. TIME OF INJURY (APPROX.) Month Day Year Hour 8 16 72 2:00 a.			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Subject was shot.			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Peter Lipkovic, M.D.				DATE SIGNED 8/16/72			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 8/19/72			
24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery				24D. LOCATION (City, town, or county) (State) Balto., Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972				25B. NAME OF REGISTRAR Lidnykh			
25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.				25D. ADDRESS 3331 Brehms Lane, Balto., Md. 21213			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07916	
K-422 72 07916				STATE OF MARYLAND - DUMFRIES	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) KOLISHKA, John D				8-16-72 1:00p M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION North Charles General Hosp.				A. STATE Maryland B. COUNTY 2642	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4339 Sheldon Ave					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/24/96	9. AGE (in years last birthday) 76	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired from MTA		10B. KIND OF BUSINESS OR INDUSTRY MTA Transit Co.		11. BIRTHPLACE (State or foreign country) Russia	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. 213-10-0927		17. INFORMANT Bertha Kolishka (wife) ADDRESS same as above	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cachexia + Malnutrition malignancy, poss. lymphoma				under 1 hr	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Metastatic Carc. to May 1972					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Pneumonia					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-14-72 to 8-16-72 that (I) (we) last saw the deceased alive on 8-16-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Manankil M.D.				23B. DATE SIGNED 8-16-72	
23C. PHYSICIAN'S NAME (Type) Ruperto MANANKIL MD				23D. ADDRESS North Charles Gen. Hosp	
24A. BURIAL CREMATION REMOVAL (Specify) BURIAL		24B. DATE 8/19/72		24C. NAME of CEMETERY or CREMATORY Gardnes of Faith Cemetery	
24D. LOCATION Balto. Md.		24E. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.		24F. ADDRESS 3337 Brehms Lane, Balto. Md. 21215	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR Andrew H. H. H.		25C. DATE OF DEATH 8-16-72	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

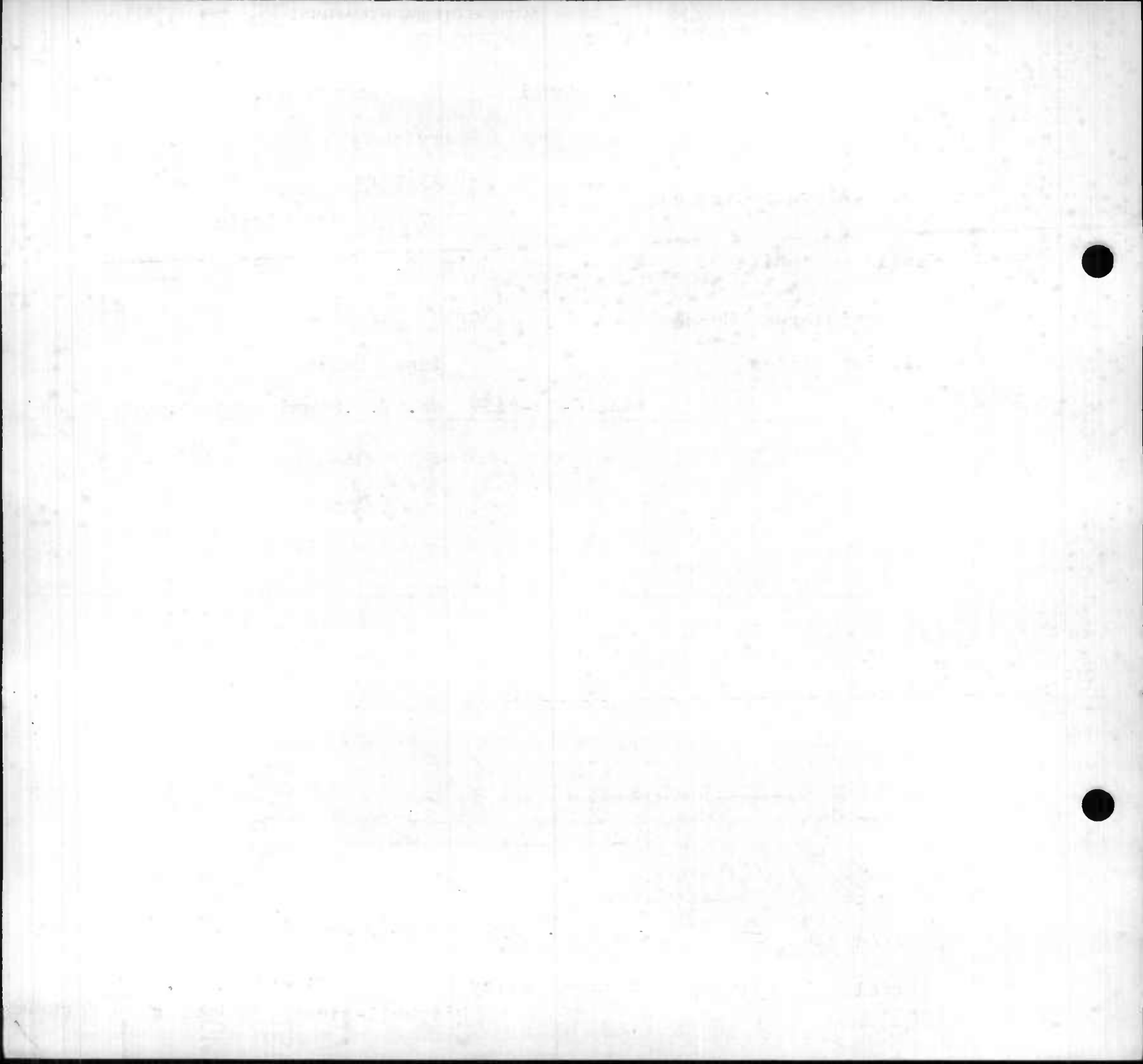
BALTIMORE CITY HEALTH DEPARTMENT									
72 07917 CERTIFICATE OF DEATH					REG. NO. 72 07917				
BIRTH NO. C-552					STATE OF MARYLAND-DEATH				
1. NAME OF DECEASED (Type or Print) COMANS, BRANDON E.					2. DATE AND HOUR OF DEATH 8/15/72 11.45P M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND B. COUNTY 2643				
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital					C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER 3557 LYNDALE AVENUE				
5. SEX M.	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 08/17/04	9. AGE (In years last birthday) 67	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			10B. KIND OF BUSINESS OR INDUSTRY Merchant Marine		11. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME unknown					14. MOTHER'S MAIDEN NAME unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 138-78-1964		17. INFORMANT Deacon Michaul, Shrine of Little Flower			ADDRESS Church	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR				
22. I certify that (I) (this hospital) attended the deceased from AUGUST 15 8:50 AM 1972 to AUGUST 15 11:45 PM 1972 that (I) (we) last saw the deceased alive on AUG. 15 11:44 PM 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE M.D.					23B. DATE SIGNED AUG. 16/1972				
23C. PHYSICIAN'S NAME (Type) DEGREE					23D. ADDRESS Union Memorial Hospital DEGREE				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/18/72		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cemetery			24D. LOCATION (City, town, or county) (State) Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972			25B. NAME OF REGISTRAR L. J. ...			25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

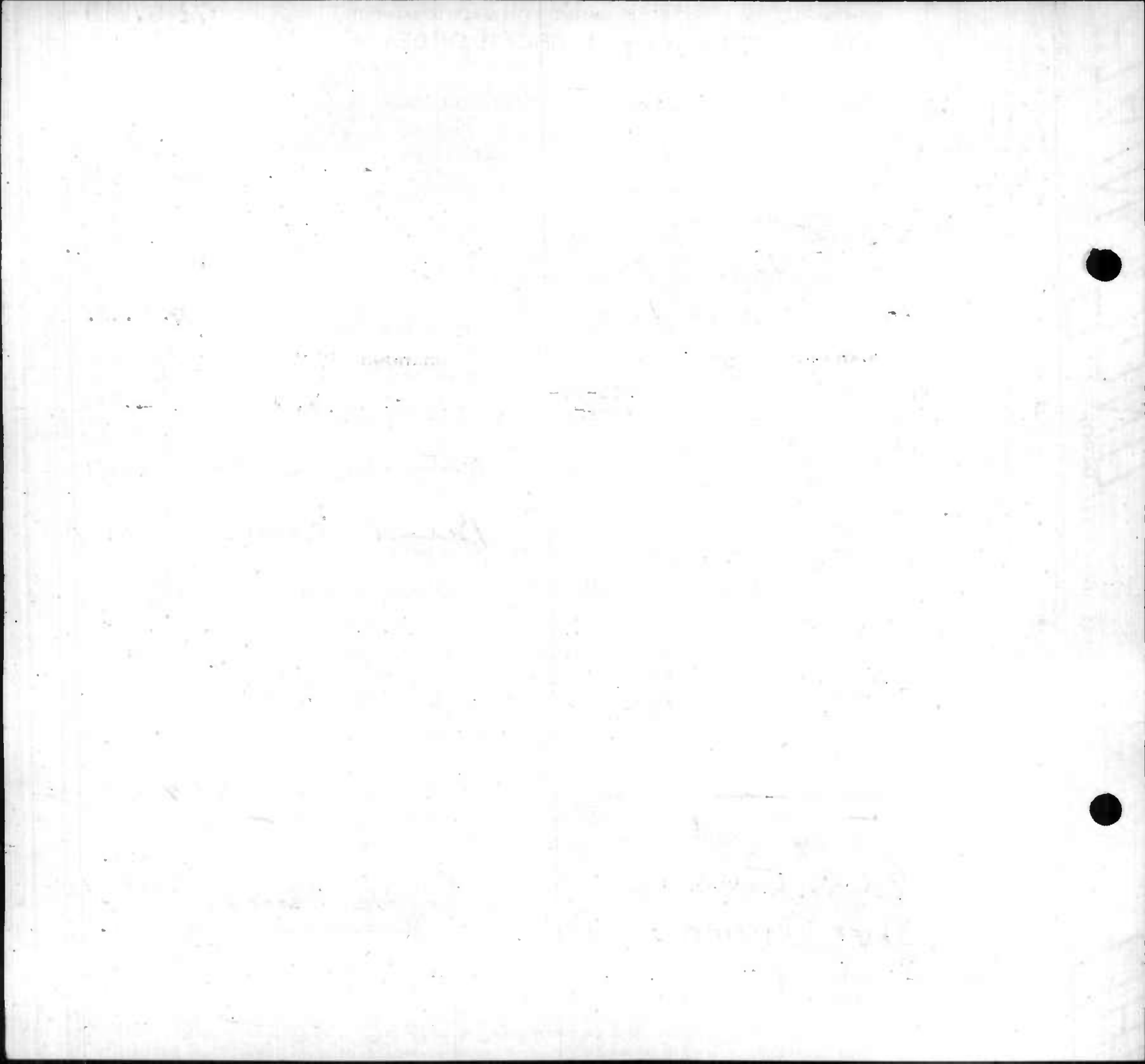
BALTIMORE CITY HEALTH DEPARTMENT				72 07918		REG. NO. 72 07918	
BIRTH NO. R-500				72 07918		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Mrs. Lillian L. Romei				2. DATE AND HOUR OF DEATH August 14, 1972 10³⁰ A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3507 Alameda Circle				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 902 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3507 Alameda Circle			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1919 53		9. AGE (In years last birthday) 53		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		
13. FATHER'S NAME William Liles			14. MOTHER'S MAIDEN NAME Iona Daniel		12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. XXX216-32-6159		17. INFORMANT Wm. T.L. Romei ADDRESS 365 Moose Hill Rd Monroe, Conn 06468		
18. 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma of cervix with metastases. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH about 2 yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-29 19 70 to 8-14 19 72 , that (I) (we) last saw the deceased alive on 7-16 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Alfred G. Ossman Jr. MD				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-15-72	
23C. PHYSICIAN'S NAME (Type) Alfred G. Ossman Jr. MD				23D. ADDRESS 1101 St Paul St Baltimore 2 MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/17/72		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley		24D. LOCATION (City, town, or county) (State) Timonium, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972				25B. NAME OF REGISTRAR Mitchell-Wiedefeld		25C. FUNERAL DIRECTOR ADDRESS Home 6500 York Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07919		REG. NO.	
7-650				72 07919		STATE OF MARYLAND - CHMH	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>FROMME Gertrude L.</u>			
2. DATE AND HOUR OF DEATH <u>8/17/72 12:00 PM</u>				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Balto</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Calm Manor Nursing Center</u>				C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>6609 FREACK Rd.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/25/1889</u>	9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months Days Hours Min. <u>1 8</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>			
11. BIRTHPLACE (State or foreign country) <u>md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Unknown HENRY FEIDLER</u>				14. MOTHER'S MAIDEN NAME <u>Unknown AGNES WEISER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>N/A</u>				16. SOCIAL SECURITY NO. <u>215-1011-3449-D</u>			
17. INFORMANT <u>Mrs. Loretta Tiggorth 1907 Frederick Ave</u>				ADDRESS			
18. <u>174X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Mitotic Cor</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Breast Cor</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Agc Ovarian cells</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Agc Ovarian cells</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7/22/55</u>			
19A. DATE OF OPERATION <u>1 7/22/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CA OF BREAST</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>2/26</u> 19 <u>68</u> to <u>8/19</u> 19 <u>72</u> , that (I) (was) last saw the deceased alive on <u>7/29</u> 19 <u>72</u> and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Cliff Ratliff Jr.</u>				23B. DATE SIGNED <u>8-18-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF JR. M.D.</u>				23D. ADDRESS <u>5772 WESTVIEW MALL BALTIMORE, MD. 21228</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-19-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lovane Park Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 21 1972</u>		25B. NAME OF REGISTRAR <u>Andrew H. Heston</u>		25C. FUNERAL DIRECTOR <u>Foley-Gorman & Co. - Catonsville, Md.</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 07920				BIRTH NO. 72 07920		BIRTH NO. 72 07920	
1. NAME OF DECEASED (Type or Print) WEBER, GEORGE ADAMS				2. DATE AND HOUR OF DEATH AUGUST 16, 1972 9:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) WILKENS & CATON AVENUE BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 5530 LINK AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 09-04-86	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - SALESMAN				10B. KIND OF BUSINESS OR INDUSTRY COMPANY AMERICAN PAPER		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME GEORGE A. WEBER, SR.				14. MOTHER'S MAIDEN NAME MARY A. (HESMAR)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW 1				16. SOCIAL SECURITY NO. 214031023		17. INFORMANT ADDRESS BALTIMORE, MD ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
18. 593.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Respiratory failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Renal failure				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from AUGUST 06 19 72 to AUGUST 16 19 72 , that (I) (we) last saw the deceased alive on AUGUST 16 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Donald T. S. A. I.</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 08/16/72	
23C. PHYSICIAN'S NAME (Type) DONALD T. S. A. I.				23D. ADDRESS BALTO MD 21229 ST AGNES HOSPITAL CATON & WILKENS AVE S			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-19-72		24C. NAME OF CEMETERY or CREMATORY Linden Park Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR <i>Shirley W. W. W.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Shirley W. W. W. Catonsville, Md.</i>			

1938, GEORGE JAMES

MARYLAND

BALTIMORE

ST AGNES HOSPITAL
WILKES & CATON AVENUE
BALTIMORE, MARYLAND

2230 LINK AVENUE

WHITE

COMPANY

RETIRED-GERMAN AMERICAN BANK

GEORGE A. WEBER, SR. (1914-1974)

1914-1974

1914-1974

1914-1974

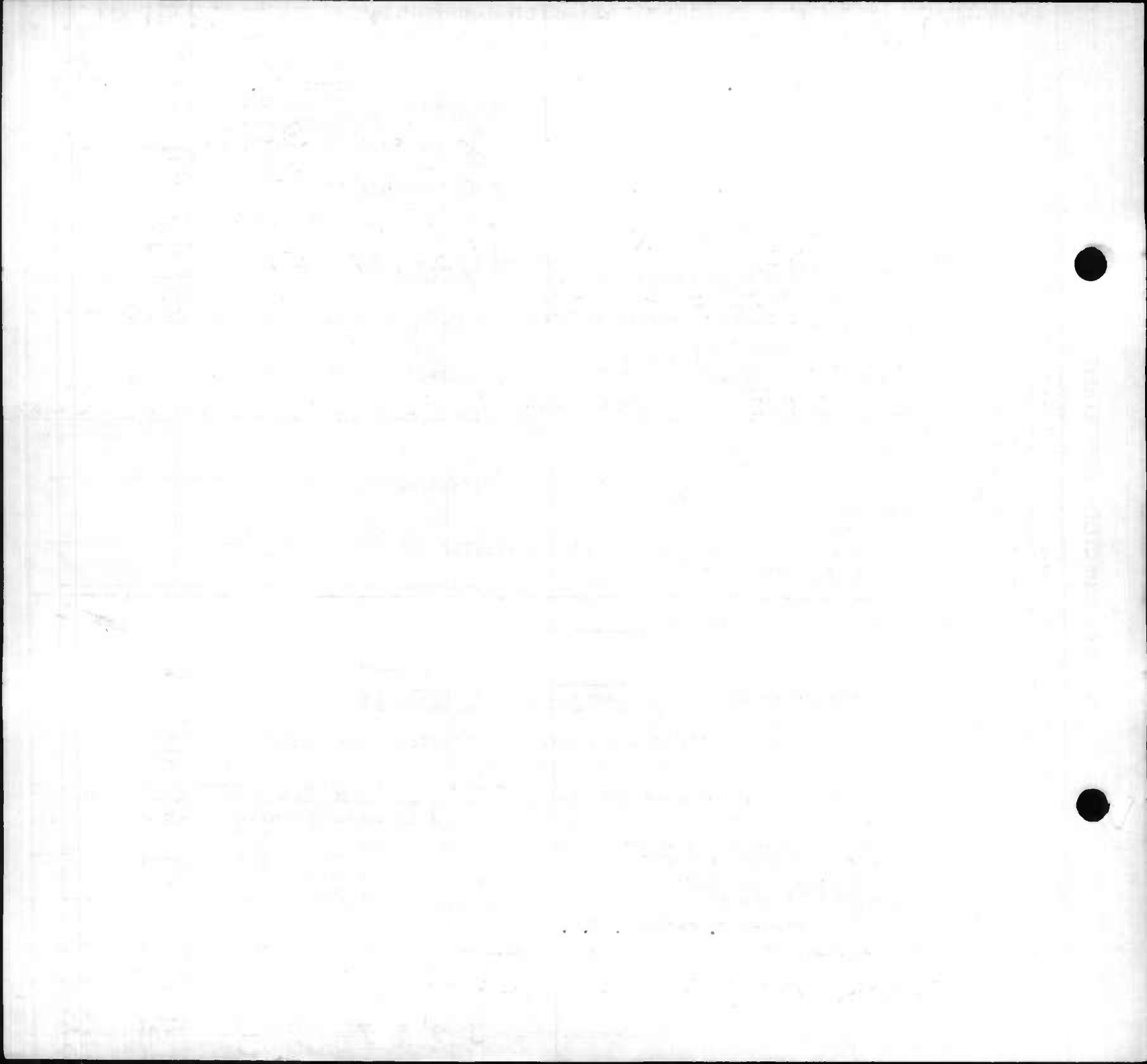
1914-1974

ST AGNES HOSPITAL CATON & WILKES AV

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

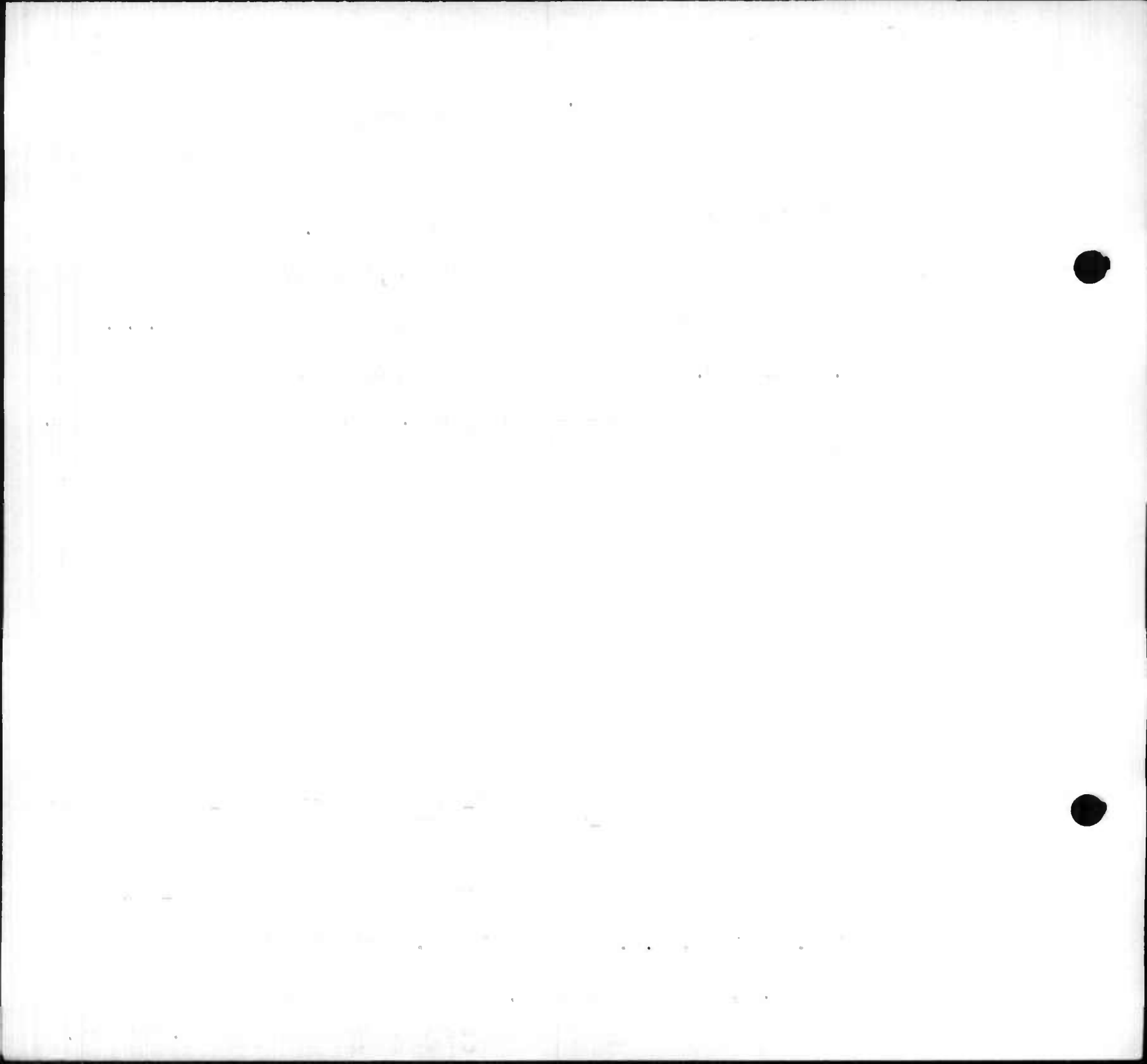
W-320		72 07921		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 72 07921	
BIRTH NO.		72 07921		CERTIFICATE OF DEATH		STATE OF MARYLAND-DEMD		REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
John H. Woods				August 15, 1972		12:05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL				A. STATE		B. COUNTY			
				Maryland		Baltimore		5300	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
				Baltimore 21215		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				6605 MT. Vernon Ave					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 28, 1916	36					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Welder + Pipe Fitter				Baltimore Electric		Shoemaker Virginia		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Robert T Woods				Lillie Moses					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes W.W.II				224-07-8539		Mrs. Mary Catherine Woods - Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES				(B) UNKNOWN PRIMARY SOURCE					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				no					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 8-9 1972 to 8-15 1972									
that (I) (we) last saw the deceased alive on 8-15 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Thomas V. Whitten M.D.									
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Thomas V. Whitten, M.D.									
24A. BURIAL OR CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		Aug 18, 72		Druid Ridge Cemetery		Pikesville Balto, Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
AUG 21 1972		L. J. King		Gusella Funeral Home		Pikesville, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-560		72 07922		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07922	
BIRTH NO.				STATE OF MARYLAND-DEMR			
1. NAME OF DECEASED (Type or Print) <u>Ernest Frederick Buehner Jr.</u>				2. DATE AND HOUR OF DEATH <u>8/17/72</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2404</u>			
5. SEX <u>Male</u>				6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>October 12, 1901</u>		9. AGE (In years last birthday) <u>71</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Ernest F. Buehner Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Henkel</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No</u> If yes, give war or dates of service	
16. SOCIAL SECURITY NO. <u>216-07-7695A</u>		17. INFORMANT <u>Marie D. Buehner (Wife)</u>		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Coronary Occlusion</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCULO - Coronary artery disease 7 yrs +</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>8-10-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>10-29</u> 19 <u>70</u> to <u>8-7</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8-7</u> 19 <u>72</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>X</u> <u>Emanuel S. Ellison, M.D.</u>				23B. DATE SIGNED <u>8-18-72</u>		23C. PHYSICIAN'S NAME (Type) <u>Emanuel S. Ellison, M.D.</u>	
23D. ADDRESS <u>107 E. West Street</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>Aug. 21, 1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Glen Burnie Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 21 1972</u>	
25B. NAME OF REGISTRAR <u>Andrew B. Houston</u>		25C. FUNERAL DIRECTOR ADDRESS <u>McGully Funeral Home 130 E. Fort Ave.</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-260		72 07923		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07923	
BIRTH NO.				STATE OF MARYLAND - DHMH			
1. NAME OF DECEASED (Type or Print) <u>Willent BAKER C.</u>				2. DATE AND HOUR OF DEATH <u>Aug. 17. 72</u> <u>10, 40 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>43</u>				E. STREET AND NUMBER <u>Light St. Harbor View Nursing Home</u>			
5. SEX <u>M</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/22/13.</u>	9. AGE in years (last birthday) <u>58</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles J.</u>				14. MOTHER'S MAIDEN NAME <u>Asma Sihamik.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>718-036328</u>		17. INFORMANT <u>Agnes H. H. H.</u>		ADDRESS <u>2333 Sidney Ave. Balt. Md.</u>	
18. <u>250.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Relaxation; severe hypoglycemic coma.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes Mellitus.</u> (C) <u></u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>D</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 17</u> 19 <u>72</u> to <u>Aug. 17</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Aug. 17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>S. Rios</u> <u>md.</u> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Aug. 17. 72.</u>	
23C. PHYSICIAN'S NAME (Type) <u>FELIPE RIOS</u> DEGREE				23D. ADDRESS <u>South Baltimore General Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-21-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore</u>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 21 1972</u>		25B. NAME OF REGISTRAR <u>Adolphus...</u>		25C. FUNERAL DIRECTOR <u>...</u>		ADDRESS <u>2347 PAFAPS W AVE</u>	

8/10/72
2333 Sidney Ave. 21230

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 07924		BALTIMORE CITY HEALTH DEPARTMENT		72 07924	
R-354		BIRTH NO.		STATE OF MARYLAND - DHMH	
1. NAME OF DECEASED (Type or Print) HENRY A. ROTHAMEL			2. DATE AND HOUR OF DEATH 8-17-72 5:15 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2643 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5837 BELAIR RD.		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-28-95	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LITHOGRAPHER		10B. KIND OF BUSINESS OR INDUSTRY MARY GOV'T.		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME AUGUST ? JOHNA ROTHAMEL			14. MOTHER'S MAIDEN NAME ELITA ? MARGARET J. KLEICHOK		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO WWI		16. SOCIAL SECURITY NO. 820-344000		17. INFORMANT ADDRESS Mrs. Catherine Miskelly, 616 GAINWAY 21061	
18. 445.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SEP T I C E M I A ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. STATUS POST ABOVE KNEE AMPUTATION LEFT LEG GANGRENE LEFT LEG			CAUSE OF DEATH SEP T I C E M I A CVA - ASCVD - GANGRENE LEFT LEG		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 8-11-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE LEFT LEG		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-29 19 72 to 8-17 19 72 that (I) (we) last saw the deceased alive on 8-17 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Tomasino, M.D.			23B. DATE SIGNED 8-17-72		23C. PHYSICIAN'S NAME (Type) RODOLFO TOMASINO, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE AUG 21 1972		
24C. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY			24D. LOCATION (City, town, or county) (State) BALTIMORE, MD. 21213		
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972			25B. NAME OF REGISTRAR Andrew J. Wilson		
25C. FUNERAL DIRECTOR GLORION FUNERAL HOME, BALTO, MD. 21206			25D. ADDRESS 21061		

11/18/69

3536 Dudley Ave. 21203

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 07925		72 07925	
P-625		72 07925		72 07925	
BIRTH NO.		REG. NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND - DMM	
PREISINGER, JOHN J.		8/16/72		5:14 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
Maryland General Hosp. 48		Md.		2642	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Balt.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		4246 Sheldon Ave			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	05-30-07	65	bartender
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		Tavern		Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		John B. Preisinger		Anna M. Maier	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		216-07-2595		William L. Preisinger, 4246 Sheldon Ave. Chart 21206	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410.9 14150X		(A) IMMEDIATE CAUSE		Cardio-Pulmonary Arrest	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B)		Myocardial Infarct	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
II		CARCINOMA of ESOPHAGUS, & METASTASES			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		YES		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (H) (this hospital) attended the deceased from 8/12 1972 to 8/16 1972 that (I) (we) last saw the deceased alive on 8/16 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Michael L. Walker M.D.				8/16/72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Michael L. Walker M.D.		Maryland General Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
burial		21 August 72		Gardens of Faith	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.			
Balto., Co., Md.		AUG 21 1972			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			
Sidney H. Hoston		Hilbert J. Home 4210 Belair			

TABLE 10-1

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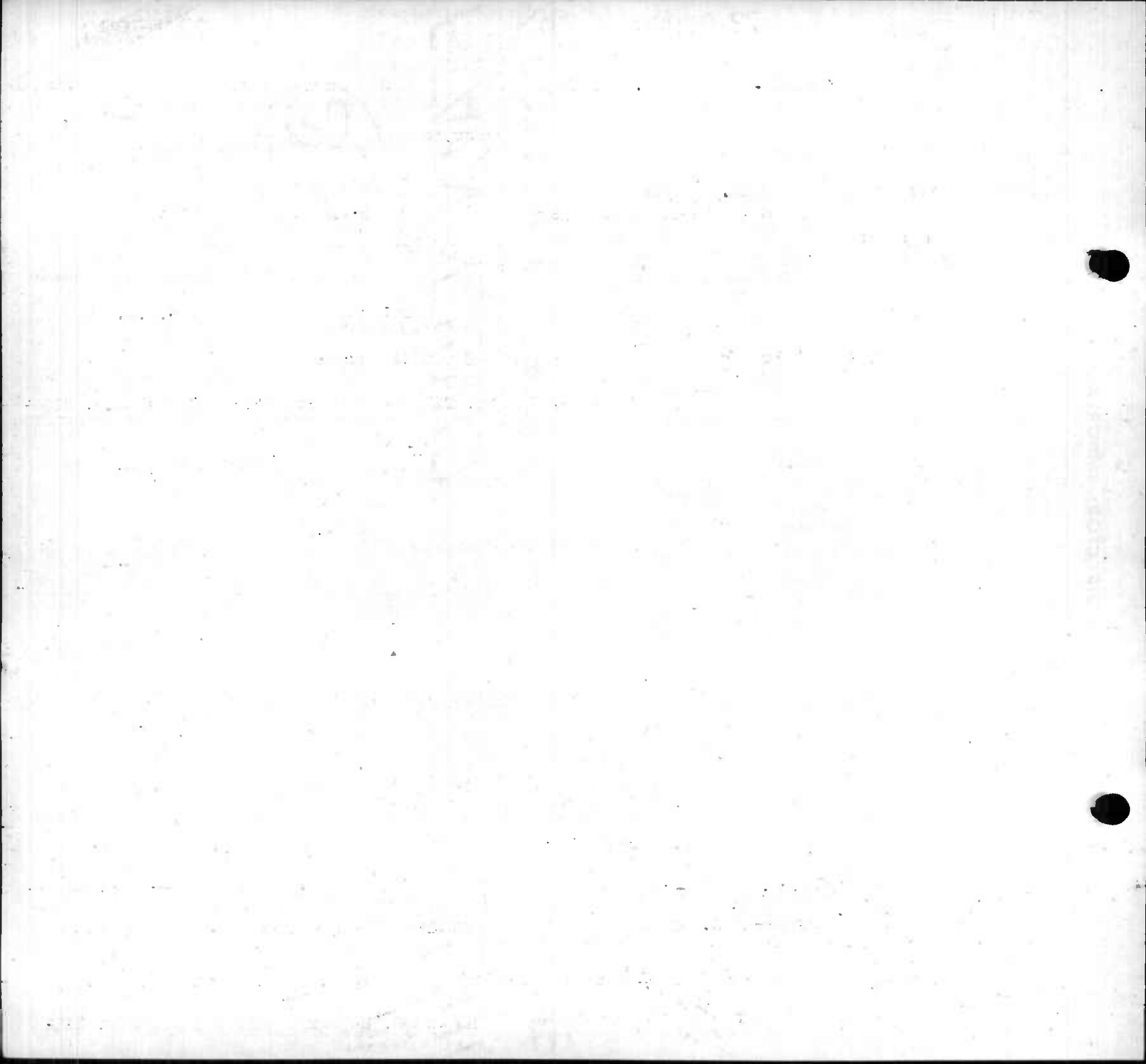
TABLE 10-1

TABLE 10-1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> B-300 72 07926 </div> <div style="display: flex; justify-content: space-between;"> BIRTH NO. CERTIFICATE OF DEATH REG. NO. 72 07926 </div>		BALTIMORE CITY HEALTH DEPARTMENT STATE OF MARYLAND-DMH	
1. NAME OF DECEASED (Type or Print) BEATRICE G. BOYD		2. DATE AND HOUR OF DEATH August 16, 1972 1:30 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="text-align: center;"> 90 Hood Nursing Home 5213 Edmondson Avenue 21229 </div>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland BALTO B. COUNTY 5300 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3613 McTavish Avenue 21229	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-9-1907
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Louis DuBritton	
14. MOTHER'S MAIDEN NAME Gertrude Bentz		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 216-03-2675		17. INFORMANT ADDRESS Mr. Tilghman Shamer, 3613 McTavish Ave. 21229	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 412.4 I Cardiac and Respiratory Arrest </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Ascar </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years </div> </div>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/16 1972 to 8/16 1972, that (I) (we) lost saw the deceased alive on See by another Doctor and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE James J. Nolan		23B. DATE SIGNED 8/17/72	
23C. PHYSICIAN'S NAME (Type) James J. Nolan		23D. ADDRESS 1 Mallow Hill Road, Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-19-1972	
24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Wash. Blvd. Howard Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR Andrew J. Hubbard	
25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

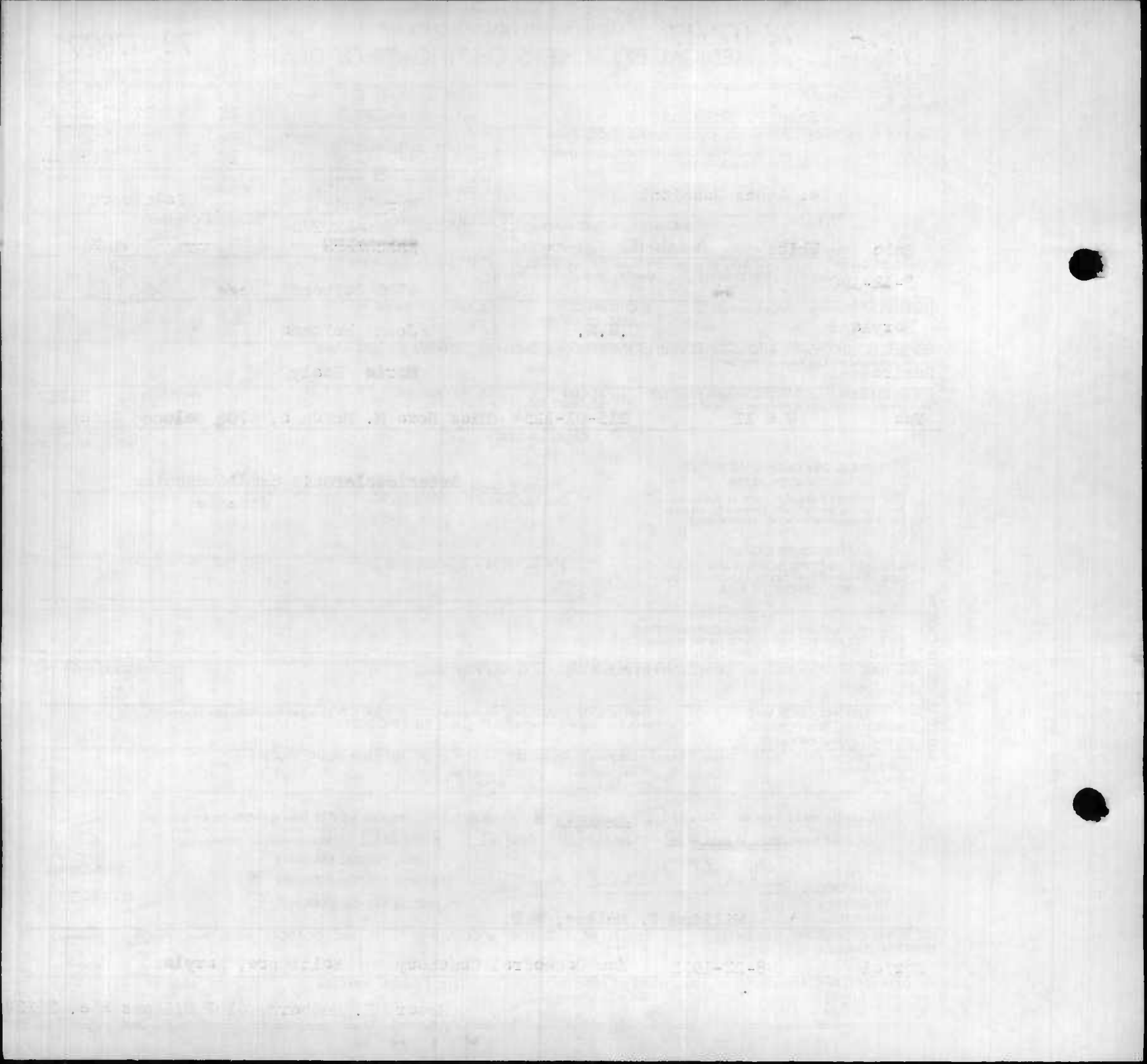
1. NAME OF DECEASED (Type or Print) John P. McKenna		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 18 72 2:50 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 18 72 2:50 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
9. DATE OF BIRTH 3-12-1908		10. AGE (in years lost birthday) 64	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME John McKenna		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
15. MOTHER'S MAIDEN NAME Marie Healy		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W II	
17. SOCIAL SECURITY NO. 215-01-1254		18. INFORMANT Miss Nora M. McKenna, 4706 Belwood Green	

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	

20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
			DATE SIGNED 8-18-72		

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-22-1972		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR Sidney [Signature]		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 07928		72 07928		CERTIFICATE OF DEATH		REG. NO. 72 07928 STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print) HANCOCK, GEORGE JOHN				2. DATE AND HOUR OF DEATH AUGUST 18, 1972 3:31 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN WOODLAWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 5535 1/2 WINDSOR MILL ROAD			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/11/17	9. AGE (In years last birthday) 54	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME ADDISON HANCOCK				14. MOTHER'S MAIDEN NAME MARY MURPHY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W W 2				16. SOCIAL SECURITY NO. 215-01-7226			
17. INFORMANT BALTO MD 21229				18. CAUSE OF DEATH ST AGNES' RECORDS CATON & WILKENS AVE			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) GI Bleeding				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Gastritis - Esophageal varices Liver cirrhosis							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
21A. DATE OF OPERATION 0		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No)		21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21E. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21F. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21H. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21I. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21J. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from AUGUST 15 19 72 to AUGUST 18 19 72 , that (X) (we) last saw the deceased alive on AUGUST 18 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.							
23A. SIGNATURE San Pedro				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) DR SAN PEDRO MD				23D. ADDRESS ST AGNES HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-21-1972		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR Audrey S. Houston		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

ST AGNES HOSPITAL

MD

DR. SAN PEDRO

DR.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07929		72 07929	
M-650				72 07929		72 07929	
BIRTH NO.				REG. NO.		STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print) ROSE EVELYN MORAN				2. DATE AND HOUR OF DEATH August 17, 1972 10:50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 GOULD'S CONVALESARIUM				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1306			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3307 Beech Avenue			
5. SEX female	6. RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/18/1892		9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John Cunningham				
14. MOTHER'S MAIDEN NAME Elizabeth Ann Devine			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. 215-10-3102			17. INFORMANT Mrs. Rose E. Cullum				
18. ADDRESS Same			19. CAUSE OF DEATH				
18. 4/2.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -	
(B) <i>Coronary Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF:			(C) _____			years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Multiple Sclerosis; "Benz" Anesthesia; Hypertension</i>						years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2/26/1963 to 8/17/1972 , that (I) (was) last saw the deceased alive on 8/16/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Albert B. Bradley</i>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) Dr. Albert B. Bradley				23D. ADDRESS 4900 Belair Road, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/21/72		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR <i>Anthony J. Horton</i>		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.-Balto, Md.		ADDRESS	

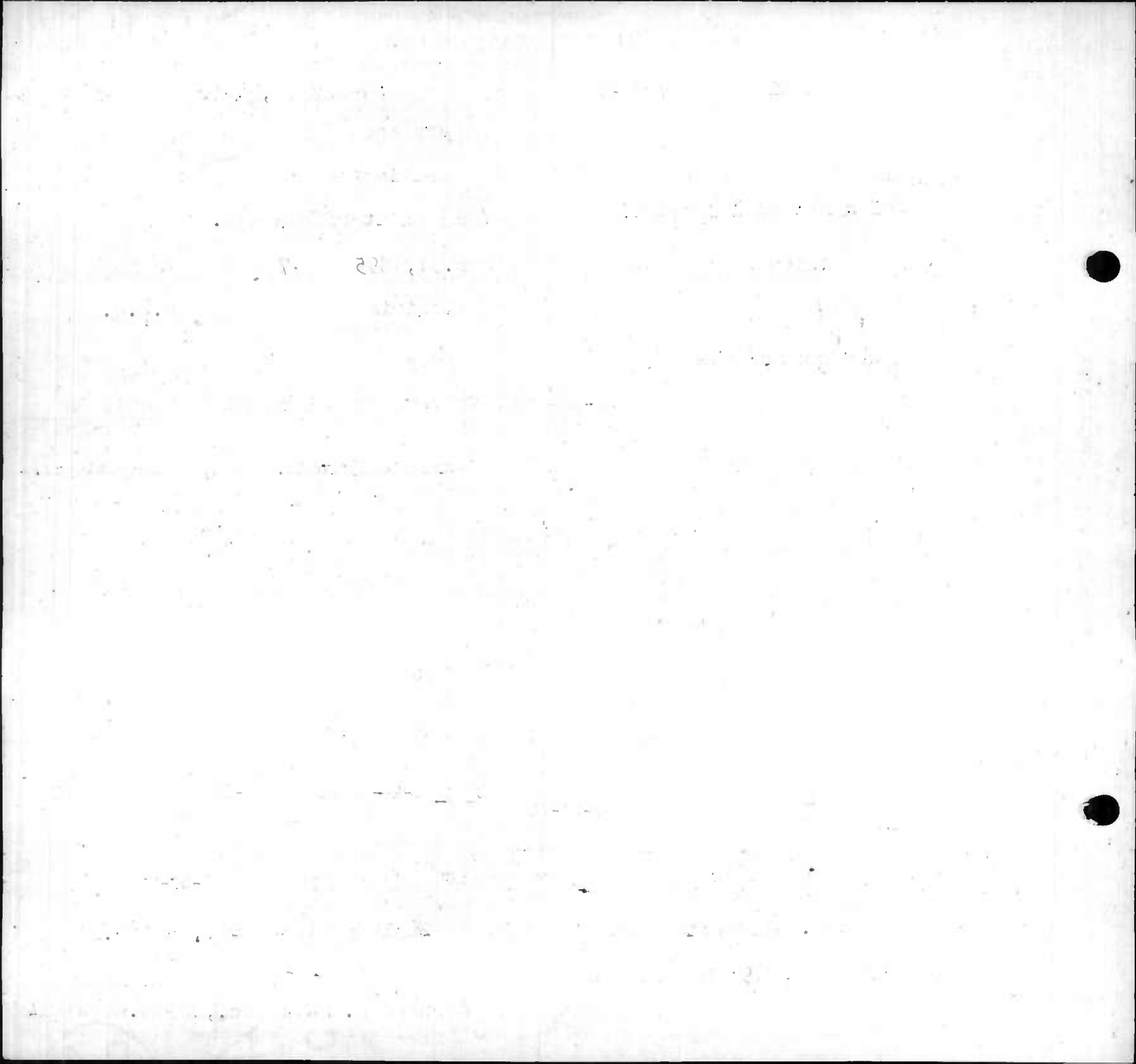
7/1/7

Ref 100. 2000. 2000-1-10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07930	
72 07930 CERTIFICATE OF DEATH				STATE OF MARYLAND-DEATH	
BIRTH NO. D-435		1. NAME OF DECEASED (Type or Print) Annie Dalton		2. DATE AND HOUR OF DEATH August 16, 1972 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY 2643			
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4013 Chesterfield Ave.			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 31, 1898	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Johnothan McPeake			
14. MOTHER'S MAIDEN NAME Judy ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 212-36-0957		17. INFORMANT ADDRESS Mr Leonard Dalton 7228 Sindall Rd			
18. 440.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) arteriosclerosis.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several yrs.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. Certify that (I) (this hospital) attended the deceased from 1-26-1960 to 8-16-1972 , that (I) (we) last saw the deceased alive on 7-28-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Ellsworth Cook M.D.		23B. DATE SIGNED 8-27-72		23C. PHYSICIAN'S NAME (Type) Dr. Ellsworth Cook	
23D. ADDRESS 2431 Maryland Ave., Balto. Md		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 8/19/72		24C. NAME OF CEMETERY or CREMATORY Dalton		24D. LOCATION (City, town, or county) (State) Floyd Co Virginia	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR Leonard J. Ruck Inc.		25C. FUNERAL DIRECTOR ADDRESS Balto. Md 21214	

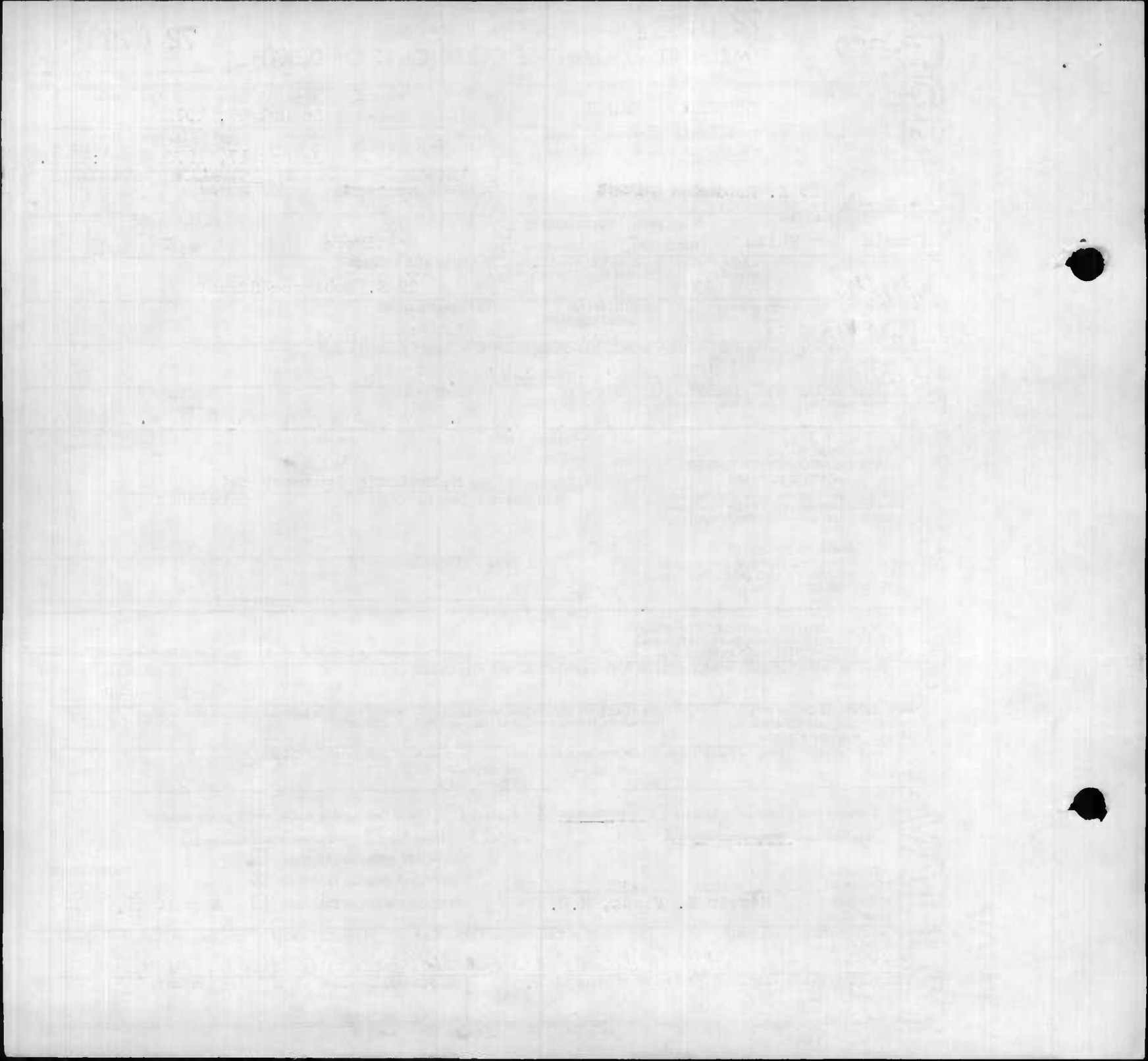


B-520

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. NAME OF DECEASED (Type or Print)		LOUETTA BANKS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year		Hour	
						August 17, 1972		M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD		Month Day Year		Hour	
29 S. Robinson Street						August 17, 1972		4:10 A.M.	
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Female		White				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
9/11/78		53		West Virginia		USA		Leslie Bancus	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
Machinist				Collison's Surgical Co.		Murtle Stanley			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS			
No				yes		Mr. Jerry Lee Henderson 402 N. Milton Ave.			
19. 1990				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE Metastatic Squamous cell carcinoma DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED						21. AUTOPSY? (Yes or No)	
0								No	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?					
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
23.									
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Marvin S. Platt, M.D.		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DATE SIGNED	
						<input checked="" type="checkbox"/>		August 17, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		8/19/72		Holly Hills Memorial Gardens		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS			
AUG 21 1972		Arden H. Heston		John A. Moran, Inc.		3020 E. Baltimore St. Baltimore, Md. 21224			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 07932		72 07932	
1. NAME OF DECEASED (Type or Print) <u>LYONS, Mary Elizabeth</u>		2. DATE AND HOUR OF DEATH <u>8/16/72</u> <u>10¹⁰ P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO - BALTON HILL Nursing Home</u>			
5. SEX <u>F</u> 6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/5/37</u> 9. AGE (in years lost birthday) <u>34</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>Michael McGraw</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Lane</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-07-8295 F</u>		17. INFORMANT <u>Mrs. Regina L. Scharper-3903 Greenmount</u>	
18. <u>205.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>ACUTE MYELOGENOUS LEUKEMIA</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ACUTE MYELOGENOUS LEUKEMIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 WEEKS</u>	
18. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>PNEUMONIA & PLEURAL EFFUSION</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/23</u> 19 <u>72</u> to <u>8/16</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/16</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Kayou V. H. MD</u>		23B. DATE SIGNED <u>8/16/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Kayou V. H.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/18/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery - Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 21 1972</u>		25B. NAME OF REGISTRAR <u>John McGraw</u>		25C. FUNERAL DIRECTOR <u>3000 E. Baltimore St. Baltimore, Md 21224</u>	

9-11-1972 - Letter from Maryland General Hospital, Signed by Rachel Joven, RRA,
Director Medical Records. HRS

72 07933

STATE OF MARYLAND-DEPT
BALTIMORE CITY HEALTH DEPARTMENT

72 07933

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JESSIE BORDEAU		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home & Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour M. 8 13 1972 2:05 p.m.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 301	
9. DATE OF BIRTH ?		10. AGE (In years lost birthday) 63	
11. BIRTHPLACE (State or foreign country) 22		12. CITIZEN OF WHAT COUNTRY? 22	
13. FATHER'S NAME Jessie T. Healer		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Healer	
15. MOTHER'S MAIDEN NAME Wesley Bordeau		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Donald C. Ogilby	
19. E 887X I		CAUSE OF DEATH Subdural hematoma	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) (HEAD ONLY)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) front of 134 S. Eden St.		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 8-11-72 7 p.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subj. fell, striking head.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
Deputy Chief Medical Examiner		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
		DATE SIGNED 8-14-72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-16-72	
24C. NAME OF CEMETERY or CREMATORY Not Cemetery		24D. LOCATION (City, town, or county) (State) Balt.	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR Audrey Whitson	
25C. FUNERAL DIRECTOR Richard H. Carroll		ADDRESS Baltimore Md	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Edward L. Bankoski		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 8 16 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1611 Cereal St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 16 72 1:15 P.M.	
6. SEX male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 2-6-15		10. AGE (In years last birthday) 57	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WALTER		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER	
15. MOTHER'S MAIDEN NAME YARCH		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7-41 11-45	
17. SOCIAL SECURITY NO. 213-09-7049		18. INFORMANT ADDRESS	
19. CAUSE OF DEATH 571.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cirrhosis of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Epilepsy			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-19-72	
24C. NAME OF CEMETERY or CREMATORY Cedar Hill		24D. LOCATION (City, town, or county) (State) Ritchie Hwy. BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR Sidney Lipkovic	
25C. FUNERAL DIRECTOR Hahn Funeral Home		25D. ADDRESS 4200 Pennington	

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FUNERAL DIRECTOR: IMPORTANT

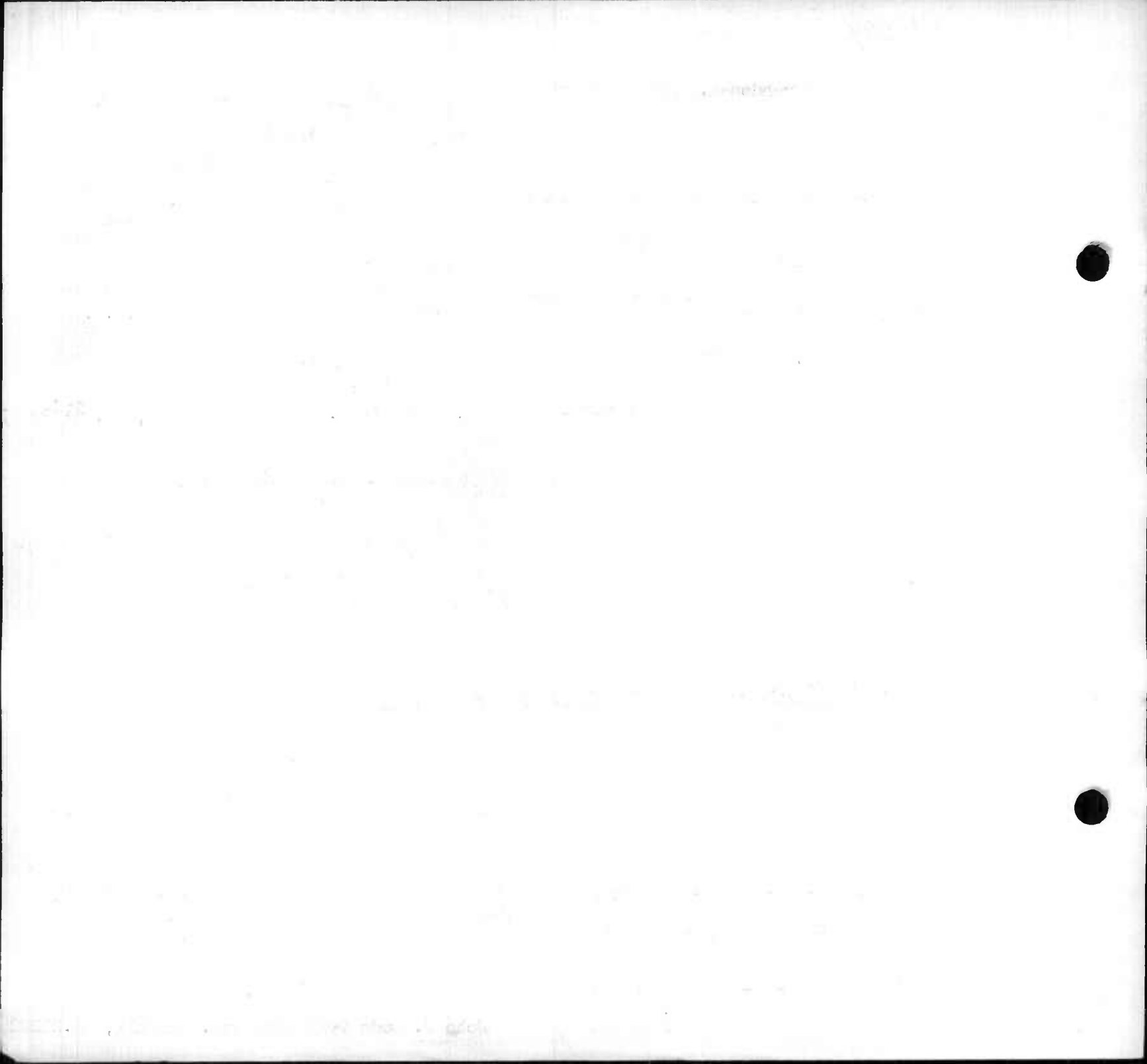
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 07935</u>
1. NAME OF DECEASED (Type or Print) <u>SOBOLAK, JOSEPH L.</u>		2. DATE AND HOUR OF DEATH <u>8/14/1972</u> <u>9.00 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE UNION MEMORIAL HOSPITAL</u> <u>33rd and CALVERT ST.</u> <u>BALTIMORE, MARYLAND 21218</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2702</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2922 GRENDALE AVENUE</u>		
5. SEX <u>M</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>08-10-08</u>	9. AGE (In years last birthday) <u>64</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AUTO.</u>		11. BIRTHPLACE (State or foreign country) <u>PA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JULIUS</u>		
14. MOTHER'S MAIDEN NAME <u>SUSAN STABRYLA</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		
16. SOCIAL SECURITY NO. <u>HJM</u> <u>219-30-7938A</u>		17. INFORMANT <u>DET.</u> <u>MRS. STEFANIE VOYAK 24615 ORANGEVIEW</u>		
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>412.4 I</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>C.V.A.</u> <u>A.S.C.V.D.</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>OFFICE WORK</u>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>JULY 13 BALTIMORE</u>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>—</u>		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>		
22. I certify that (I) (this hospital) attended the deceased from <u>JULY 14</u> <u>1972</u> to <u>AUGUST 14</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>AUGUST 14</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Inducto Gaudin, M.D.</u>				23B. DATE SIGNED <u>8/14</u>
23C. PHYSICIAN'S NAME (Type) <u>CARLOS H. SANTILLAN</u>		23D. ADDRESS <u>33rd and CALVERT STREETS</u> <u>BALTIMORE, MARYLAND 21218</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/17/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>OAKLAWN CEMETERY</u>
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 21 1972</u>		
25B. NAME OF REGISTRAR <u>—</u>		25C. FUNERAL DIRECTOR <u>RAYMOND H. KACZOROWSKI</u>		
25D. ADDRESS <u>3525 FLEET ST.</u>		25E. ADDRESS <u>—</u>		

2922 GRINDON AVE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

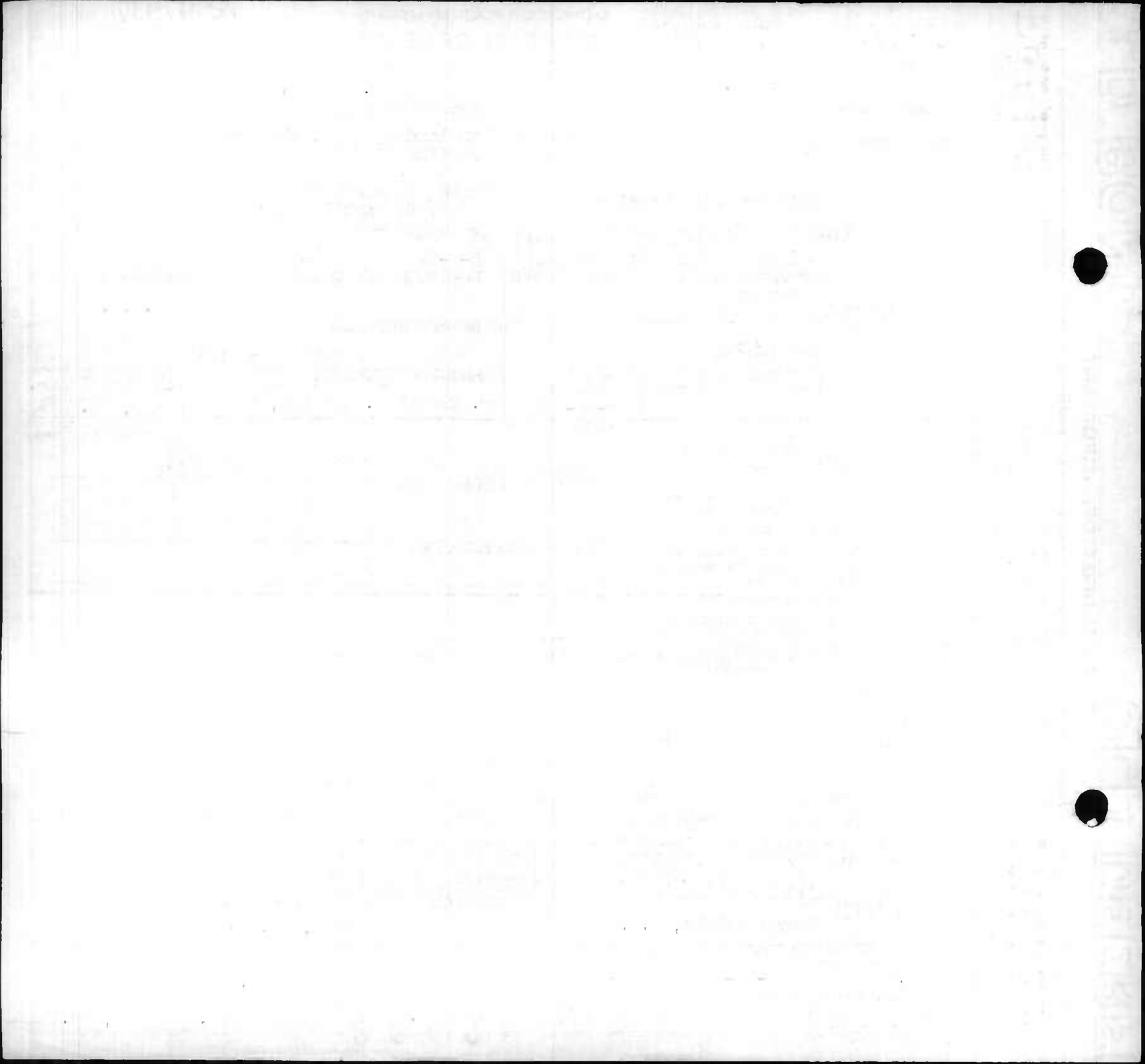
BALTIMORE CITY HEALTH DEPARTMENT				72 07936		REG. NO. 72 07936	
BIRTH NO. 11-624				72 07936		STATE OF MARYLAND-DEPT. OF HEALTH	
1. NAME OF DECEASED (Type or Print) Brendon L. Marshall				2. DATE AND HOUR OF DEATH Aug. 15 '72 7:50P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SINAI HOSP. of BALTIMORE				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSP. of BALTIMORE				C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 7307 School Ave. # 22							
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/09/14	9. AGE (In years last birthday) 57	10. Under 1 Tr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fork Lift Operator				10B. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal		11. BIRTHPLACE (State or foreign country) Maine	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Ray C. Marshall			
14. MOTHER'S MAIDEN NAME Marion Sleeper				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II			
16. SOCIAL SECURITY NO. 217-18-0356				17. INFORMANT Wife: Mrs. Cornelia I. Marshall ADDRESS 7307 School Ave. Dundalk, Md. 21222			
18. 530.3 I CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Respiratory failure 1 day DUE TO, OR AS A CONSEQUENCE OF: (B) Broncho pneumonia 3-5 days DUE TO, OR AS A CONSEQUENCE OF: (C) Esophageal stricture			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 7/19/72				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Esophageal stricture		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/11/72 to 8/15/72 that (I) (we) last saw the deceased alive on 8/15/72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. Michelson				23B. DATE SIGNED Aug. 15 '72		23C. PHYSICIAN'S NAME (Type) E. MICHELSON	
23D. ADDRESS SINAI HOSP. OF BALTIMORE							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-19-72		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR Linday H. Hinton		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md. 21222	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07937		72 07937	
C-252 72 07937				BIRTH NO.		REG. NO.	
72 07937				STATE OF MARYLAND-DEME		M.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Jean E. Cushing				August 16, 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
31 Baltimore City Hospital				Maryland		Baltimore	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER			
				6905 Markel Avenue			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3-7-29	43			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife						U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Lloyd Poling				Esther Campbell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				234-44-0542		Husband: 6905 Markel Ave. Dundalk, Md. 21222	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Acute Myocardial Infarction			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19__ to 19__ that (I) (we) last saw the deceased alive on 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
George Hebeka, M.D.							
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. FUNERAL DIRECTOR		23F. ADDRESS	
		7151 Holabird Avenue Dundalk, Md. 21222		John J. Duda		7922 Wise Ave. Dundalk, Md. 21222	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-19-72		Oak Lawn Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
AUG 21 1972		Sidney Johnson		John J. Duda		7922 Wise Ave. Dundalk, Md. 21222	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07938	
BIRTH NO. A-352 72 07938				STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print) TAMMIE LYNN ADAMS			2. DATE AND HOUR OF DEATH AUG 16, 1972 11:40 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITAL 4900 Eastern Ave. Baltimore, Md. 31			A. STATE MARYLAND Baltimore C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2964 Sollers Point Road 2964 Sollers Rd.		
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/24/72	9. AGE (In years (last birthday)) 0	10. Under 1 Yr. Months: 0 Days: 23
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME PATRICK ADAMS		
14. MOTHER'S MAIDEN NAME DEBORAH ATKINS			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. NONE			17. INFORMANT ADDRESS 4940 Eastern Ave. BCH Records: Baltimore, Md. 21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) TRACHEOESOPHAGEAL PISTULA DUE TO, OR AS A CONSEQUENCE OF: (C) PREMATUREITY		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 55 MIN 23 DAYS 23 DAYS			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION 7/25 - 8/10		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TERSTULA AND ASPIRATION PNEUMONITIS		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 7/24 1972 to 8/16 1972 that (we) last saw the deceased alive on 8/16 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph T. Marino M.D.				23B. DATE SIGNED Aug 16, 1972	
23C. PHYSICIAN'S NAME (Type) JOSEPH T. MARINO MD				23D. ADDRESS Baltimore City Hospitals 4940 Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-19-72		24C. NAME of CEMETERY or CREMATORY Meadowridge Memorial Park	
24D. LOCATION (City, town, or county) Dorsey, Maryland		(State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR Andrew J. [Signature]		25C. FUNERAL DIRECTOR John J. Duda 7922 Wise Ave. Dundalk, Md. 21224	

DEBORAH BLKINS
MARYLAND

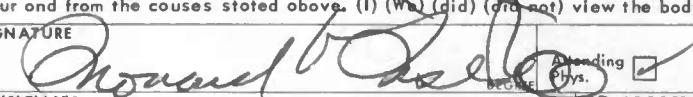
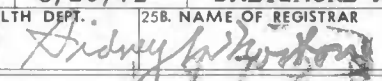
PATRICK ADAMS

1/24/72

28

FUNERAL DIRECTOR: IMPORTANT

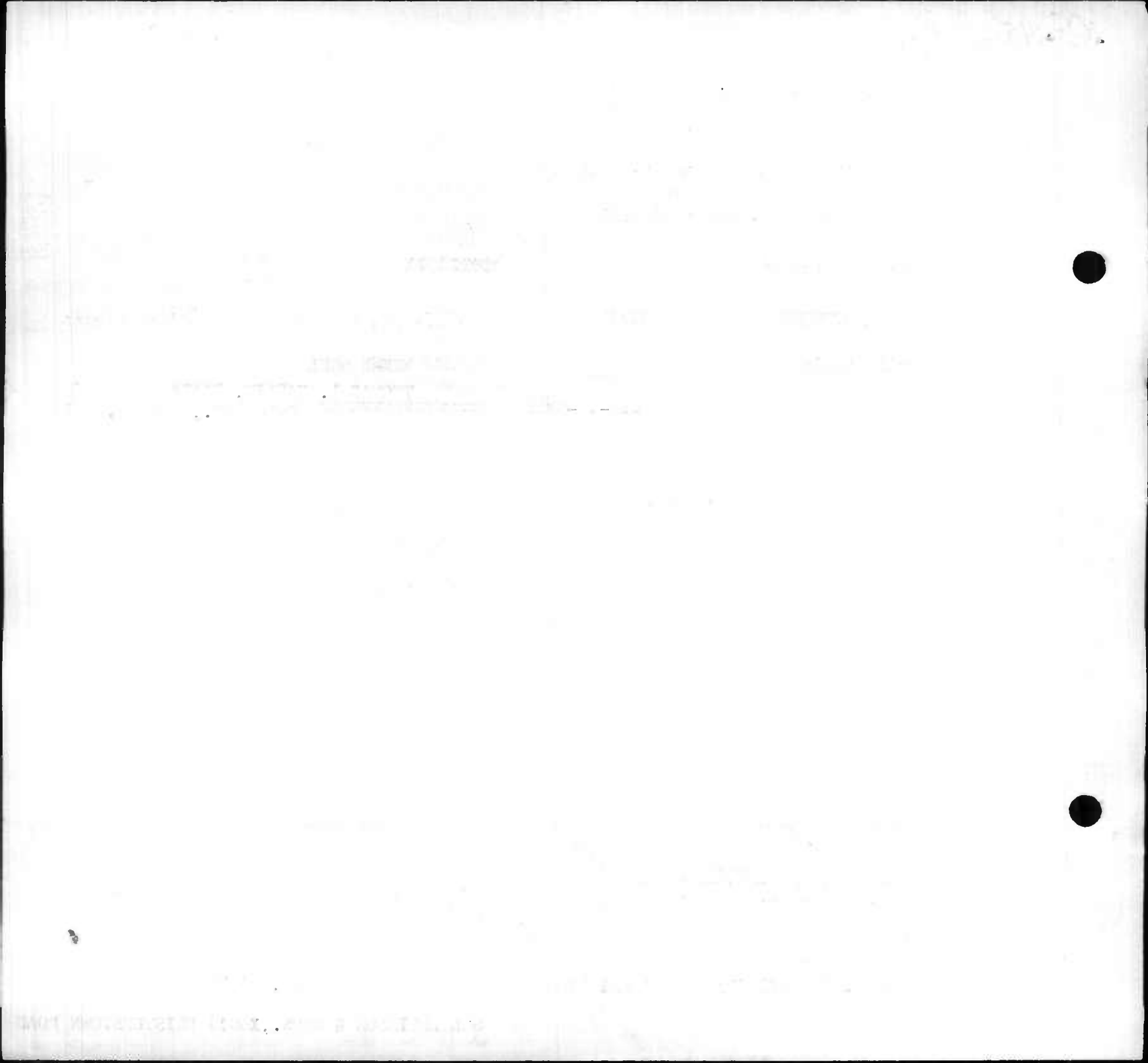
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07939	
72 07939				72 07939	
S-316				STATE OF MARYLAND-DEME	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SAMUEL C. STOFBERG		AUGUST 16, 1972 11:23 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
SINAI HOSPITAL			MARYLAND BALTO 5300		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3502 OLD COURT ROAD #21208		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8/20/1908	63	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
PRESIDENT			BALTIMORE, MARYLAND		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
ALLIED BEDDING CO.			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
NATHAN STOFBERG			ROSE KARCHER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO					MR. DENNIS PUSHKIN, 400 S. CHARLES ST. #21201
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Acute Myocardial Infarction		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) ASHD - Diabetes		
			(C) _____		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from _____ 1965 to _____ 8/16 1972, that (I) (we) last saw the deceased alive on _____ 8/13 1972 and that in (my) (our) opinion death occurred on the date _____ and hour _____ from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE					23B. DATE SIGNED
					
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS
LEONARD LISTER					7111 PARK HEIGHTS AVENUE
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		8/20/72		BALTIMORE HEBREW	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 21 1972				SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

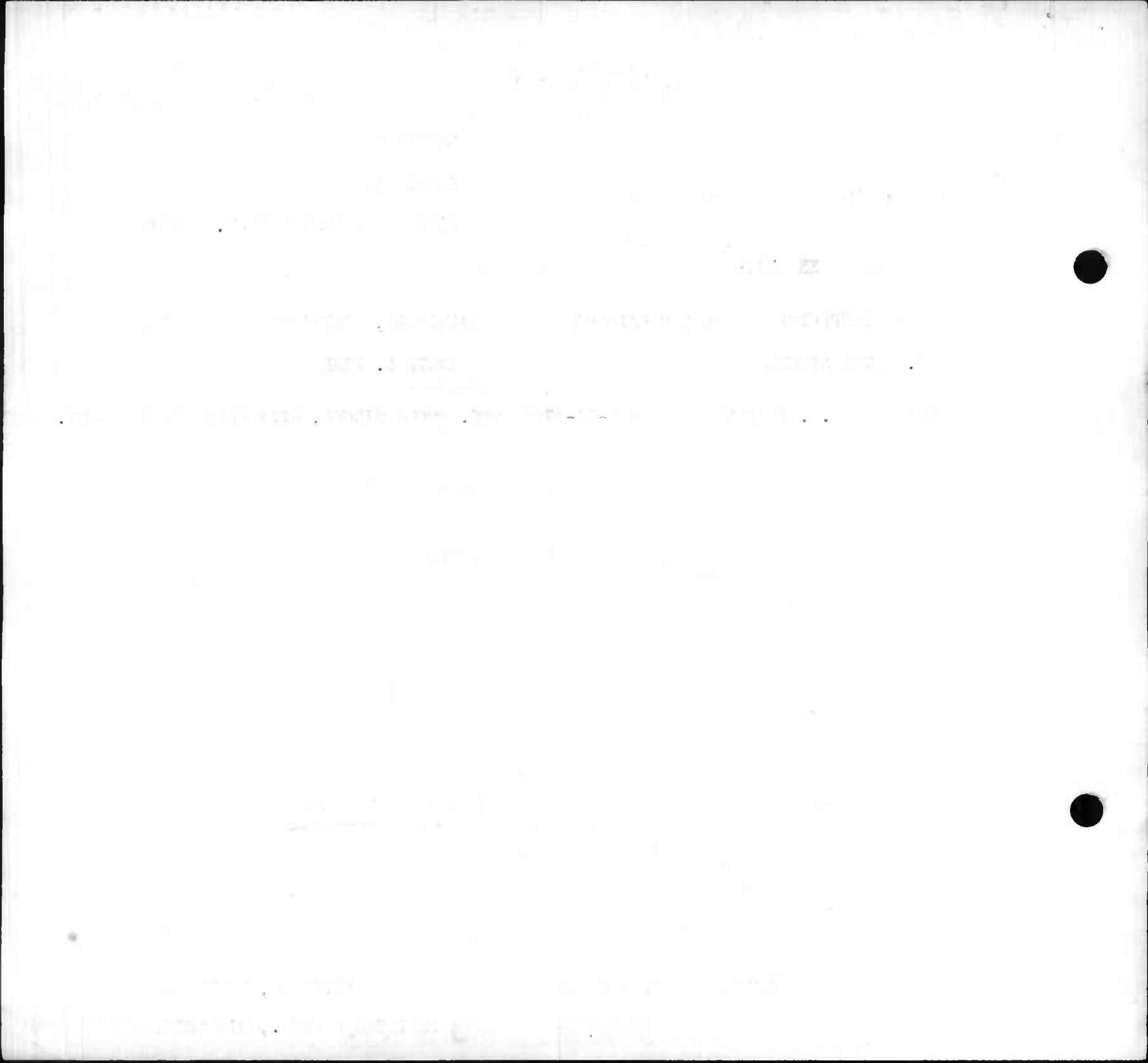
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 07910	STATE OF MARYLAND-DHMH
C-14501 K-145		72 07910			
1. NAME OF DECEASED (Type or Print) Miss Sarah Kaplin (CAPLAN)			2. DATE AND HOUR OF DEATH 8-16-72 9:40 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Seton Psychiatric Institute 6400 Wabash Avenue Baltimore, Maryland 21215			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Pikesville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 8201 Nina Court		
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH XXXXXX	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS		10B. KIND OF BUSINESS OR INDUSTRY SHOP		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Morris Kaplin			14. MOTHER'S MAIDEN NAME Mollie NOEL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-10-0323A		17. INFORMANT THOMAS L. KAPLIN, PLAZA HOTEL MONROE ST., TOLEDO, OHIO	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 686.9 I Rough Pneumonia Gran Granate Sepsis Infected Hip Stenosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 19 71 to August 16 1972 that (I) (we) last saw the deceased alive on August 16 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edmundo KARRANAGO			23B. DATE SIGNED 8-16-72		23C. PHYSICIAN'S NAME (Type) Edmundo KARRANAGO M.D.
24A. BURIAL CREMATION REMOVAL (Specify) BURIAL		24B. DATE 8/18/72		24C. NAME of CEMETERY or CREMATORY SHAAREI ZION	
24D. LOCATION ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972			
25B. NAME OF REGISTRAR Friday		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., X6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

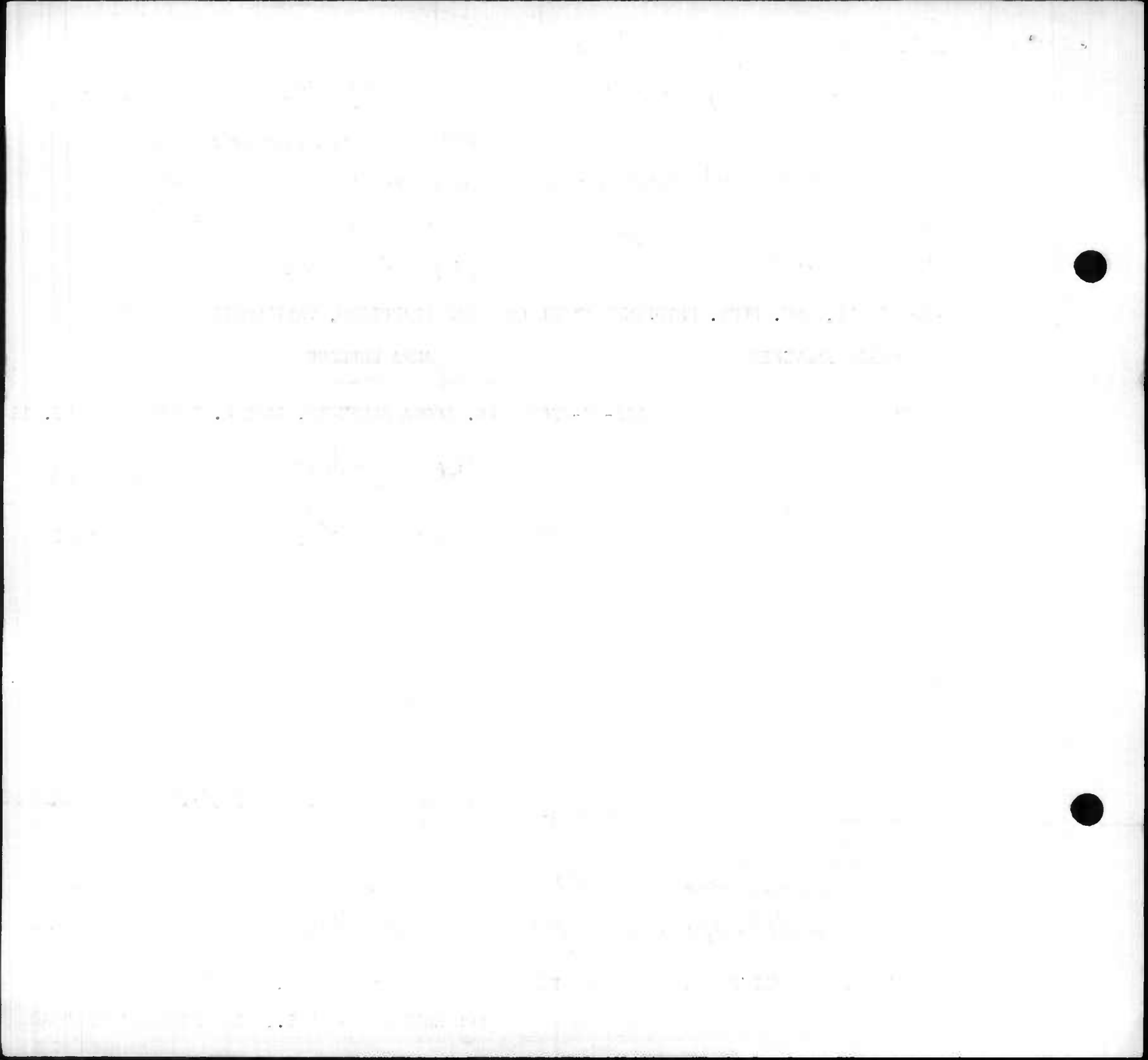
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>S-240 72 07911 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 1.2em;">CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 07911</p> <p>STATE OF MARYLAND-DEATH</p>	
<p>BIRTH NO. 5-240</p> <p>1. NAME OF DECEASED (Type or Print) SIEGEL GABRIEL JOSEPH</p>		<p>2. DATE AND HOUR OF DEATH 8-15-72 12 02 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>SINAI HOSPITAL OF BALTIMORE INC.</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE MARYLAND 8. COUNTY 2755</p> <p>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 6128 GREEN MEADOW PKWY. #21209</p>	
<p>5. SEX MALE</p>	<p>6. RACE WHITE</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 3-28-98</p>
<p>9. AGE (In years last birthday) 74</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCH INSPECTOR</p>	
<p>11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME C. MEYER SIEGEL</p>		<p>14. MOTHER'S MAIDEN NAME ANNIE L. FINE</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. I ARMY</p>		<p>16. SOCIAL SECURITY NO. 407-14-4786</p>	
<p>17. INFORMANT MRS. RHODA SIEGEL</p>		<p>ADDRESS 6128 GREEN MEADOW PKWY. #21209</p>	
<p>18. 4270 I + 162.1</p> <p>CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE Cerebrovascular accident hours</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) Chronic Atrial Fibrillation 5 year</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) Chronic congestive Cardiorespiratory year</p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> <p>Carcinoma Lung</p>			
<p>19A. DATE OF OPERATION 7-26-72</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No</p>	
<p>20A. AUTOPSY? (Yes or No) No</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (U) (this hospital) attended the deceased from 7-26-72 to 8-15-72 that (U) (we) last saw the deceased alive on 8-15-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (U) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Prasad MB</p>		<p>23B. DATE SIGNED 8-15-72</p>	
<p>23C. PHYSICIAN'S NAME (Type) P. PRASAD MB</p>		<p>23D. ADDRESS Sinai Hospital, Balto md 21215</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL</p>		<p>24B. DATE 8/17/72</p>	
<p>24C. NAME OF CEMETERY or CREMATORY MIKRO KODESH</p>		<p>24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972</p>		<p>25B. NAME OF REGISTRAR Sidney Whorton</p>	
<p>25C. FUNERAL DIRECTOR SOB LEVINSON & BROS.</p>		<p>ADDRESS 6010 REISTERSTOWN ROAD</p>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

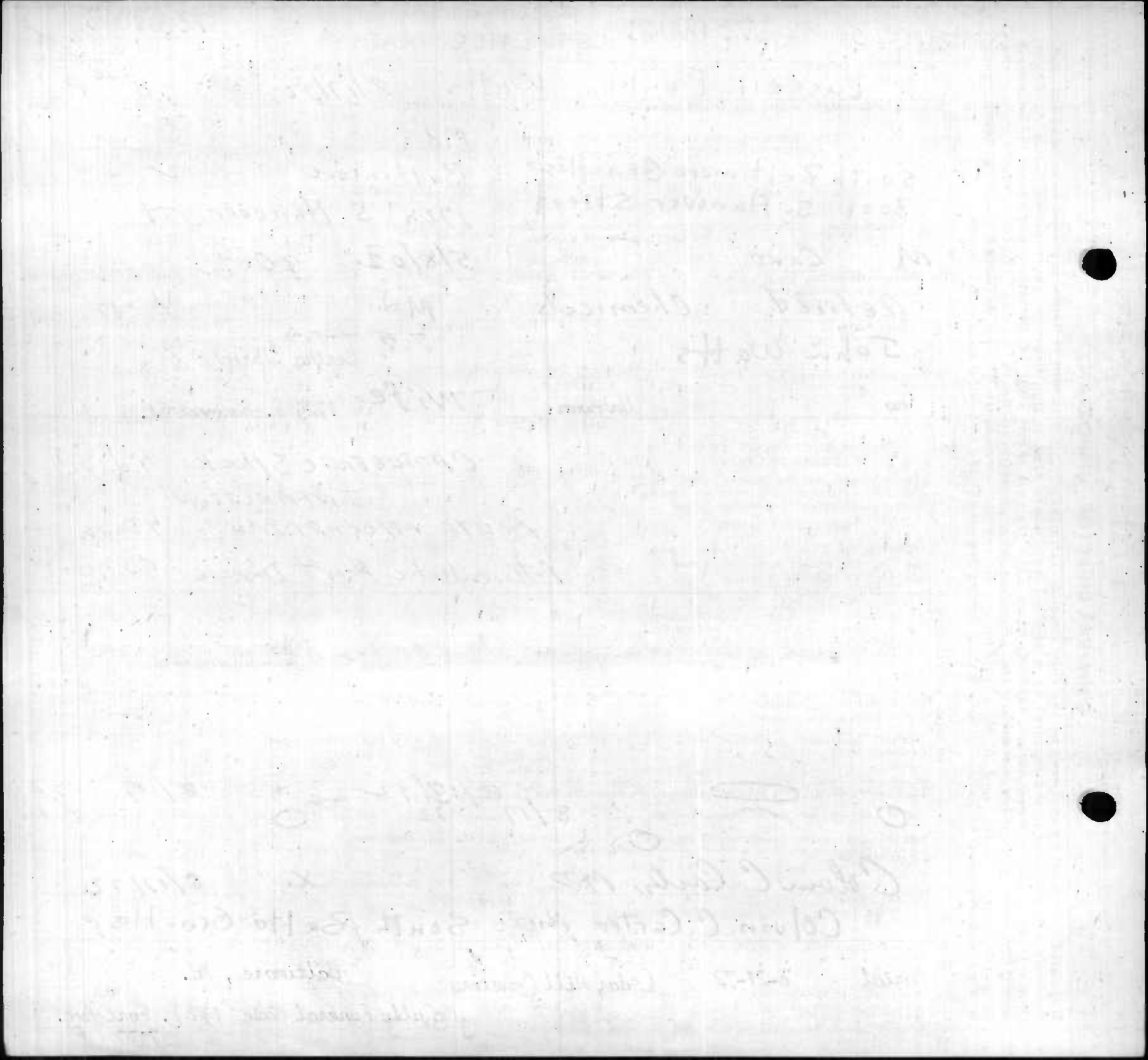
5-432		72 07942		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07942	
BIRTH NO.		CERTIFICATE OF DEATH				STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) SLUTZKIN, GEORGE				2. DATE AND HOUR OF DEATH 8/15/72 7:00 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI Hospital of BALTIMORE				A. STATE MD B. COUNTY BALTIMORE			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
4-2				E. STREET AND NUMBER 3502 W. Strathmore Av #15			
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/11/1905	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHIEF CLERK, ENG. DEPT.		10B. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL CO		11. BIRTHPLACE (State or foreign country) SAN FRANCISCO, CALIFORNIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MORRIS SLUTZKIN				14. MOTHER'S MAIDEN NAME ANNA BERKOFF			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-09-0202		17. INFORMANT ADDRESS MRS. LEONA SLUTZKIN, 3502 W. STRATHMORE AVE. #15			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Pump Failure DUE TO, OR AS A CONSEQUENCE OF: (Cardiopulmonary shock)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
				(B) Massive Aortic M.I. DUE TO, OR AS A CONSEQUENCE OF:		11 days	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/4/72 to 8/15/72 that (I) (we) last saw the deceased alive on 8/15/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE K. MICHAELIDES MD				23B. DATE SIGNED 8/15/72		Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) K. MICHAELIDES MD				23D. ADDRESS SINAI HOSPITAL OF BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/17/72		24C. NAME of CEMETERY or CREMATORY HEBREW FRIENDSHIP		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR Sidney [unclear]		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07943 STATE OF MARYLAND
W-320 72 07943		BIRTH NO.		
1. NAME OF DECEASED (Type or Print) Russell Franklin Watts		2. DATE AND HOUR OF DEATH 8/17/72 8:10 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2303		
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore Gen. Hosp. 3001 S. Hanover Street		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1725 S. Hanover St.				
5. SEX M	6. RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/8/03	9. AGE (In years last birthday) 69 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Chemicals		11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME John Watts		14. MOTHER'S MAIDEN NAME Bertha Albright		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Wife 1725 S. Hanover St.
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIOGENIC SHOCK INFARCTION (B) ACUTE MYOCARDIAL DUE TO, OR AS A CONSEQUENCE OF: (C) Arteriosclerotic Heart Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days Sec-years
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 8/18/72 19 to 8/17 19 72 , that (I) (we) lost saw the deceased alive on 8/17 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Colvin C. Carter, M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/17/72
23C. PHYSICIAN'S NAME (Type) Colvin C. Carter M.D.		23D. ADDRESS South Balto. Gen. Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-21-72		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR Lidney Johnston		25C. FUNERAL DIRECTOR McGully Funeral Home 130 E. Fort Ave. 21230



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07944

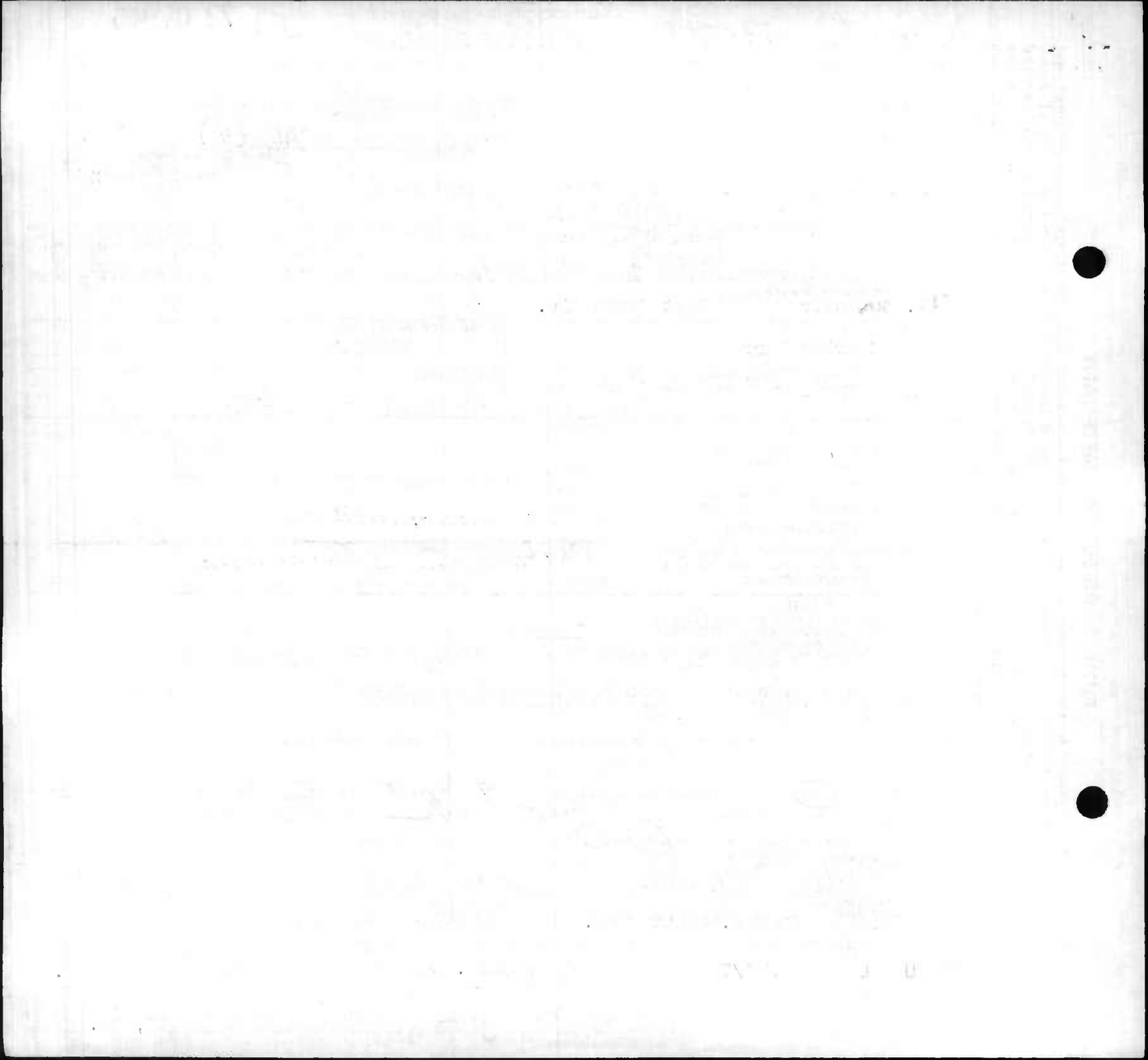
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Moky or MOKEY ABRAMUK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 824 W. Lombard Street		3. DATE PRONOUNCED DEAD Month Day Year July 26, 1972 Hour 8:25 P.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Oct 1899		10. AGE (In years lost birthday) 72	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tailor		14B. KIND OF BUSINESS OR INDUSTRY Clothing	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212 03 2025	
18. INFORMANT Anthony Abramuk		ADDRESS 2311 Sidney Avenue 21240	
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 27, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug 18 1972	
24C. NAME OF CEMETERY or CREMATORY Holy Trinity Cemetery		24D. LOCATION (City, town, or county) (State) Elkridge Howard Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR DIPPEL	
25C. FUNERAL DIRECTOR DIPPEL		ADDRESS BROSINC 1800 E LOMBARD ST	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

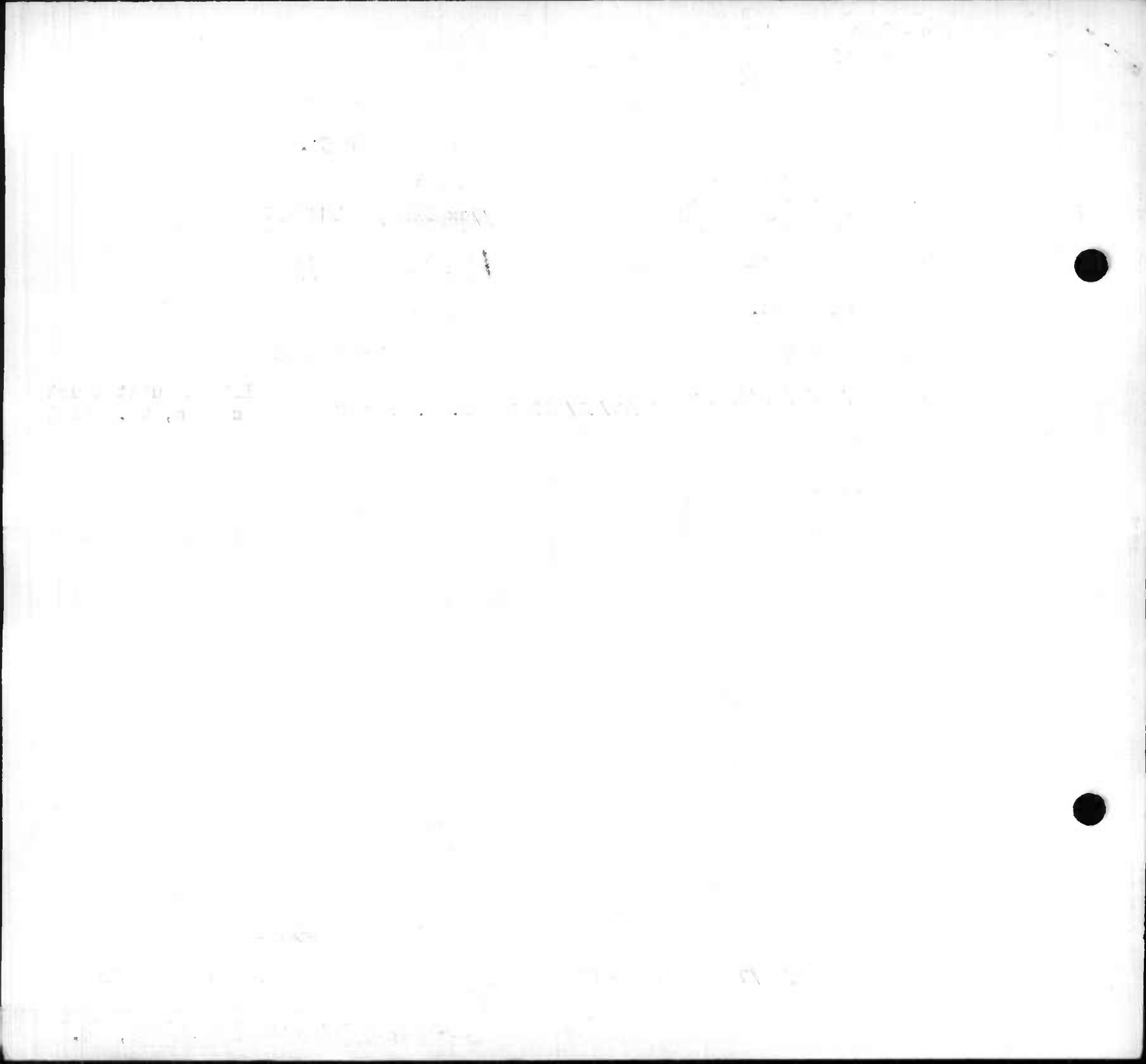
C-600		72 07945		BALTIMORE CITY CITY HEALTH DEPARTMENT		72 07945	
BIRTH NO.		72 07945		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		Carr Joseph F.		2. DATE AND HOUR OF DEATH		8-16-72 1 23 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
MARYLAND GENERAL HOSPITAL		MD. A. ARUNDAL (4)		GLEN BURNIE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
MALE		W		11-20-06		71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RET. Engineer		Fort Meade Civ.		MD.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
Charles Carr		UNKNOWN		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> WW I		220-16-5194	
17. INFORMANT		18. CAUSE OF DEATH		19. MEDICAL CERTIFICATION		20. DATE OF OPERATION	
FRIEND - JOSEPHINE WIECHMAN		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Post pneumonia for (B) DUE TO, OR AS A CONSEQUENCE OF: Bronchogenic carcinoma (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 14 August 1972 to 16 August 1972 that (I) (we) last saw the deceased alive on 16 August 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
John E. Miller		8/16/72		JOHN E. MILLER MD.		MARYLAND GENERAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		8/21/72		DAVIDSONVILLE METH. CHURCH CEMETERY		DAVIDSONVILLE Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
AUG 21 1972		David J. Swartz		David J. Swartz		SINGLETON FUNERAL HOME GLEN BURNIE, MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-520 72 07946		BALTIMORE CITY HEALTH DEPARTMENT		72 07946	
CERTIFICATE OF DEATH		REG. NO.		72 07946	
BIRTH NO. <u>MRS. LAURA OWENS</u>		STATE OF <u>MARYLAND-DMH</u>			
1. NAME OF DECEASED (Type or Print) <u>MRS. LAURA OWENS</u>		2. DATE AND HOUR OF DEATH <u>8/17/72 2:50 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>AA Co.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>BON SECOURS HOSP.</u> <u>42025 FAYETTE ST.</u> <u>BALTO. MD.</u>		C. CITY OR TOWN <u>SEVERN</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Fem.</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER Ret.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		8. DATE OF BIRTH <u>1/8/93</u>	
13. FATHER'S NAME <u>GEORGE GARY</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET SAKERS</u>		9. AGE (in years last birthday) <u>79</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217/05/03180</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
		17. INFORMANT <u>Mr. E. GOROON OWENS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
		ADDRESS <u>1300 Capitol Court</u>		<u>Mr. E. GOROON OWENS</u>	
				<u>Mo: Lean, Va. 22101</u>	
18. <u>153.0 I</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE <u>CARDIO-RESPIRATORY FAILURE</u>		<u>5 min.</u>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) <u>CARCINOMA ASCENDING COLON & METASTASIS</u>		<u>2 years.</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>July 28, 1972</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>1) CA Descending colon</u> <u>2) Ventral hernia</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that (I) (this hospital) attended the deceased from <u>July 14</u> 19 <u>72</u> to <u>August 17</u> 19 <u>72</u>		21F. HOW DID INJURY OCCUR?			
that (I) (we) lost saw the deceased alive on <u>August 16</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>S. Vamvanis, MD</u>		23B. DATE SIGNED <u>August</u>		23C. PHYSICIAN'S NAME (Type) <u>S. VAMVANIS, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/19/72</u>		24C. NAME of CEMETERY or CREMATORY <u>FRIENDSHIP CEMETERY</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 21 1972</u>		25B. NAME OF REGISTRAR <u>Shirley Houston</u>		25C. FUNERAL DIRECTOR <u>David J. Korbath</u>	
				ADDRESS <u>SINGLETON FUNERAL HOME</u> <u>GLEN BURNIE, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 07947		72 07947	
S-315		72 07947		72 07947	
BIRTH NO.		REG. NO.		STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
STEVENS, MARY E.		8/12/72 10:15 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL 40 BALTO., MD.		A. STATE B. COUNTY MARYLAND BALTIMORE			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 2819 Michigan Avenue		F. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6 9 11		9. AGE (In years last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Secretary	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME OSCAR L LEE	
14. MOTHER'S MAIDEN NAME EMMA (JACKSON)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-10-2680	
17. INFORMANT Mr. Herbert G. Stevens, 2819 Michigan Ave. ST AGNES HOSPITAL, BALTO., MD.		18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) BILATERAL BASAL PNEUMONIA. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF: (C) old h/o C.V.A. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
19. DATE OF OPERATION 2		20. AUTOPSY? (Yes or No) YES		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
22. I certify that (X) (this hospital) attended the deceased from 8/11/1972 to 8/12/1972, that (X) (we) last saw the deceased alive on 8/12/1972 and that (X) (our) opinion of death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.		23. SIGNATURE HARSHIT SINGH M.D. 23C. PHYSICIAN'S NAME (Type) HARSHIT SINGH M.D. 23D. ADDRESS St Agnes Hospital, Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-16-72		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	
24D. LOCATION Wash. Blvd. Howard Co., Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972			
25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 07948	
G-400 72 07948				STATE OF MARYLAND-DHMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GALE, HENRY O, JR		8 12 72 10:40 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL, BALTO., MD. 40			A. STATE B. COUNTY MARYLAND BALTIMORE		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
			BALTIMORE WOODLAWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER			1625 INGLESIDE AVE - APT 5		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6 11 94	78	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED/AUDITOR		State of Maryland		MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
O. HENRY GALE, SR			ANNIE (SHANNON)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES WW1		217 10 9270		Mrs. Bessie R. Gale, 1625 Ingleside Ave. ST AGNES HOSPITAL, BALTO., MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
2					YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XX (this hospital) attended the deceased from 8 5 1972 to 8 12 19 72, that XX (we) last saw the deceased alive on 8 12 19 72 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
J. J. Mol				8/13/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
J. J. Mol				ST. AGNES HOSPITAL BALTO MD 21229	
24A. BURIAL CREMATION/REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8-16-1972		Woodlawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 21 1972		Sidney H. Hubbard		Howell H. Hubbard, 4107 Wilkens Ave. 21229	

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SALE HENRY

WYLAND JALMINE

AT ARMY HOSPITAL, BALTO., MD.

1000 HIGHER AVE - 2ND F.

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WHITE

WYLAND

RECEIVED

WHITE (BROWN)

WHITE

1111 1111 ST ARMY HOSPITAL, BALTO., MD.

WHITE

YES

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ST. ARMY HOSPITAL, BALTO., MD.

WHITE

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WHITE

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72 07949

STATE OF MARYLAND-DEPT
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07949

BIRTH NO.

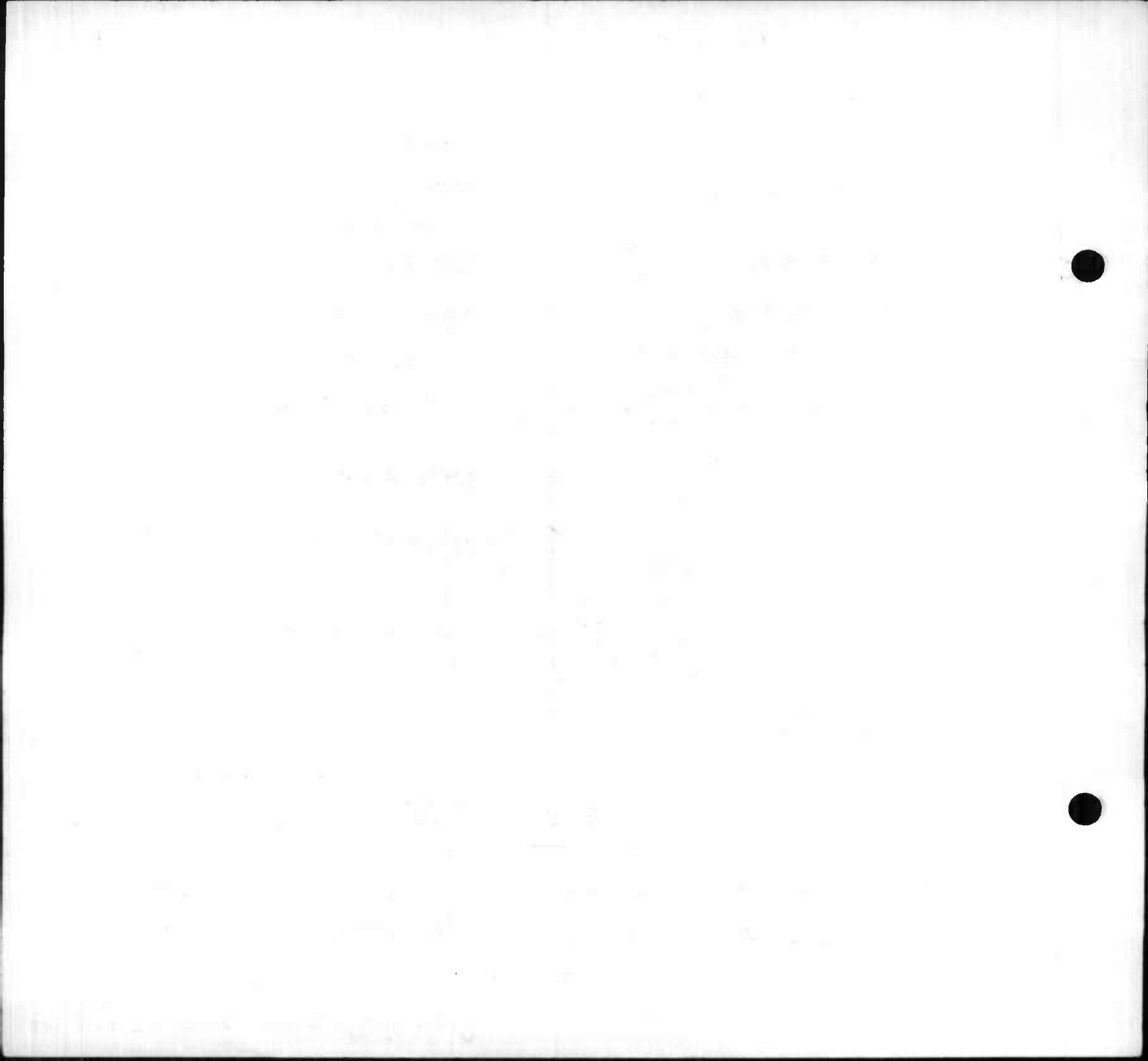
1. NAME OF DECEASED (Type or Print) SHIRLEY JOHNSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1700 Eutaw Place		3. DATE PRONOUNCED DEAD Month Day Year Hour August 14, 1972 2:00 P. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10/29/35		10. AGE (In years last birthday) 36	
11. BIRTHPLACE (State or foreign country) Chattanooga, Tenn		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Glen Holliday		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Willie Henderson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs Jeanette Horton	
19. 303.9		ADDRESS 1240 E 24th St	
CAUSE OF DEATH Columbus Ohio		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Acute Ethylism DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. DATE SIGNED 8/15/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/21/72	
24C. NAME OF CEMETERY or CREMATORY Chatanooga		24D. LOCATION (City, town, or county) (State) Tennessee	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR <i>Sidney H. Horton</i>	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	

9-1-1972 - Completion of cause of death on a pending medical examiner death certificate
Ronald N. Kornblum, M.D. HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

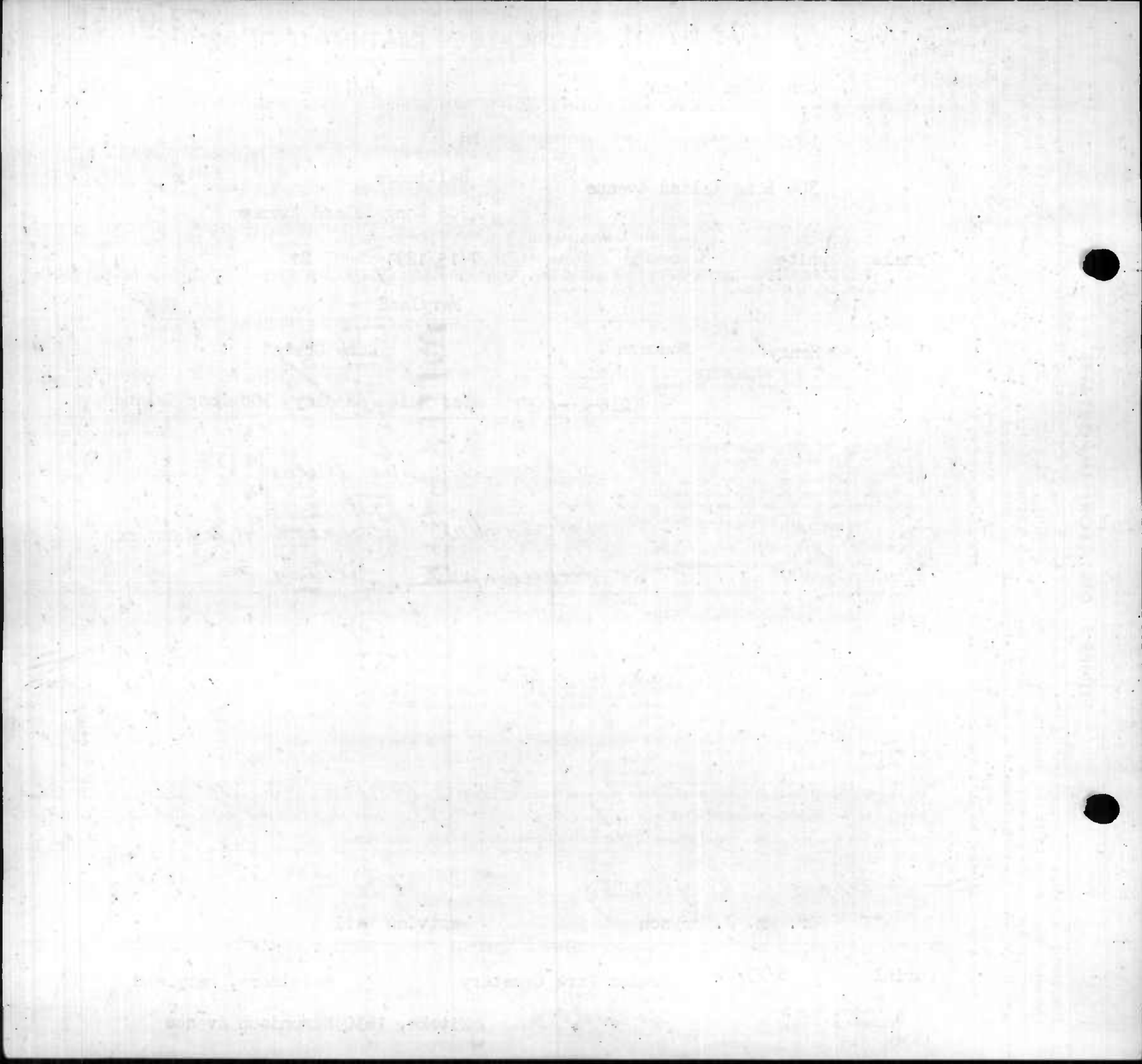
A-352 72 07950		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 07950 STATE OF MARYLAND-DEM	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOHN T ADAMS		2. DATE AND HOUR OF DEATH 8/15/72 1220 P	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2101		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 675 W BARRE ST. 21230	
5. SEX MALE	6. RACE BLACK	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/10/26	9. AGE (In years last birthday) 46	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME HENRY ADAMS		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT CHART-VIA-WIFE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CARDIAC ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HOURS			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE ANTEROLATERAL M.I.		2 WEEKS	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). TUBERCULOSIS / ALCOHOLISM / HEPATITIS					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8/5/72 19 72 to 8/15 19 72 that (I) (we) last saw the deceased alive on 8/15 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Paul D. Light M.D.		23B. DATE SIGNED 8/15/72		23C. PHYSICIAN'S NAME (Type) PAUL D. LIGHT M.D.	
23D. ADDRESS UNIVERSITY HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/22/72	
24C. NAME OF CEMETERY or CREMATORY MT Auburn Cemetry		24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972	
25B. NAME OF REGISTRAR Adolphus Halstead		25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

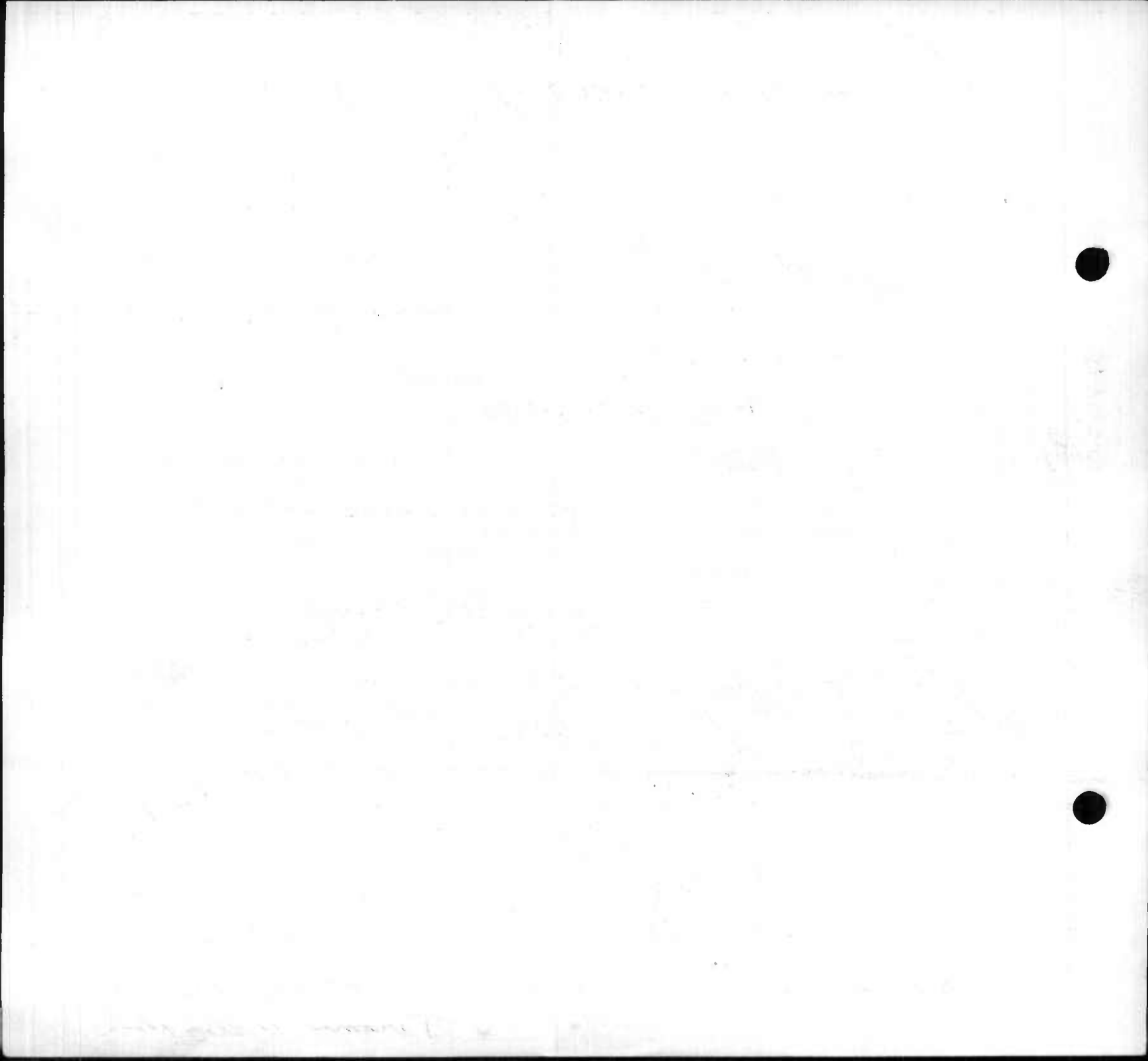
BALTIMORE CITY HEALTH DEPARTMENT				72 07951		72 07951	
S-140				72 07951		72 07951	
BIRTH NO.				72 07951		72 07951	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Anna Rosa Shipley				8/19/72 9:30 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
00 308 Long Island Avenue				Md			
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9. AGE (In years last birthday) 10. AGE (In years last birthday)			
female white				7/15/1891 81			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Henry Neumann				Anna Christ			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
216-46-4457				Miss Helen Shipley 308 Long Island Ave. 21229			
18. 15-4-1 I CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				Cardiac failure			
ANTECEDENT CAUSES				(B) MYOCARDIAL DEGENERATION & ANEMIA			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) CARCINOMA OF RECTUM			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
1970 Carcinoma of rectum				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>				22. I certify that (I) (this hospital) attended the deceased from June 1971 19 to 19 Aug 1972, that (I) (we) last saw the deceased alive on 19 Aug 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE				23B. DATE SIGNED			
William J. Bryson M.D.				21 Aug 72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Wm. J. Bryson				Westview Mall			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				8/23/72			
24C. NAME OF CEMETERY OR CREMATORY				24D. LOCATION (City, town, or county) (State)			
Loudon Park Cemetery				Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
AUG 21 1972				Witzke, 1630 Edmondson Avenue			



FUNERAL DIRECTOR: IMPORTANT

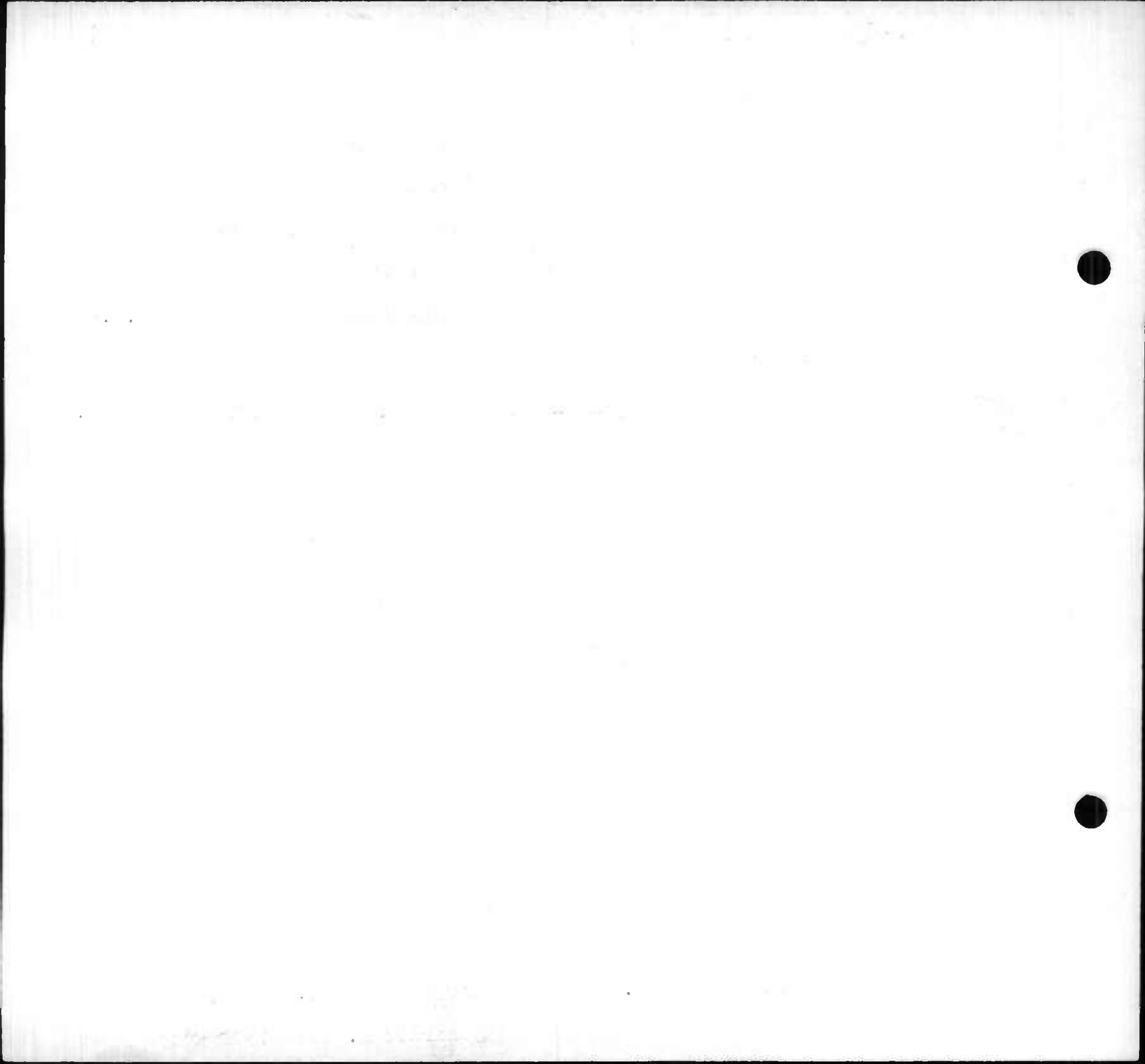
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-530		72 07952		BALTIMORE CITY HEALTH DEPARTMENT		72 07952	
BIRTH NO.		72 07952		CERTIFICATE OF DEATH		REG. NO. STATE OF MARYLAND-DEMH	
1. NAME OF DECEASED (Type or Print) JOSEPH NEMETHY				2. DATE AND HOUR OF DEATH 8/16/72 4:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME & HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 103			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2315 - EASTERN AVE			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 05-01-89		9. AGE (In years last birthday) 83	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) HUNGARY		12. CITIZEN OF WHAT COUNTRY? AMERICA	
13. FATHER'S NAME JOHN NEMETHY				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 217-14-6093		17. INFORMANT ADDRESS			
18. 4100 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). MITRAL REGURGITATION, ATRIAL FIBRILLATION, PNEUMONIA, URRAEMIA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 8.9.72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PEPIC ULCER, MASSIVE GI HAEMORRHAGE		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? NO INJURY			
22. I certify that (I) (this hospital) attended the deceased from 7/22/72 19__ to 8/16/1972 that (I) (we) last saw the deceased alive on 8/16/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/16/72	
23C. PHYSICIAN'S NAME (Type) CEAR P. VELUZ				23D. ADDRESS CHURCH HOME & HOSPITAL, 100 N BROADWAY, BALTO, MD 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/19/72		24C. NAME OF CEMETERY or CREMATORY SACRED HEART		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR [Signature]		ADDRESS [Signature]	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

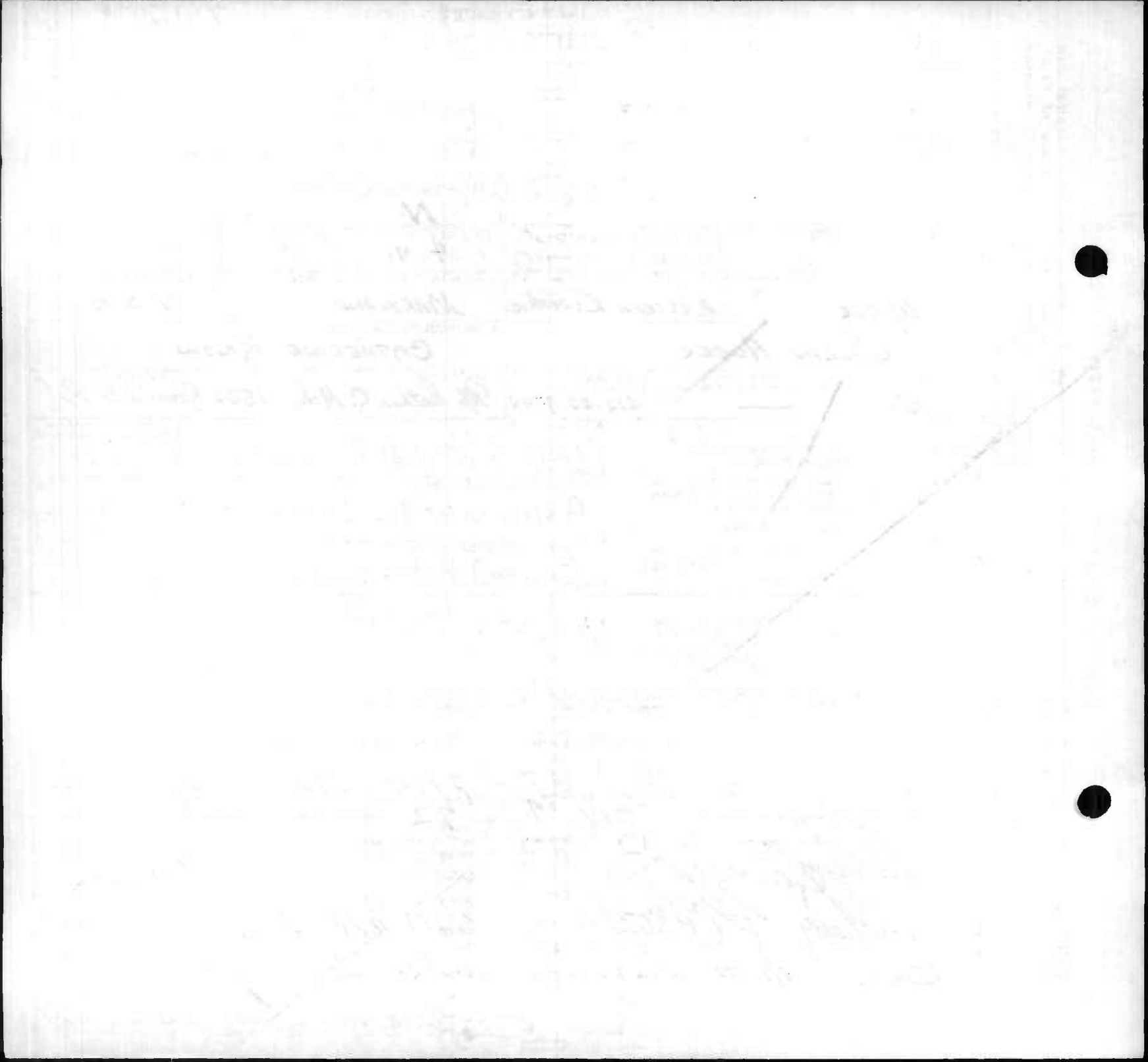
<p>3-530 72 07953 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 07953</p> <p>STATE OF MARYLAND-DHMH</p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) <i>SMITH BYZELLA.</i></p>		<p>2. DATE AND HOUR OF DEATH <i>8-16-72 11:55 A.M.</i></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Lutheran Hospital Maryland</i></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1601</i></p> <p>C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <i>1210 Riggs Ave.</i></p>	
<p>5. SEX <i>male</i></p>	<p>6. RACE <i>negro</i></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <i>9-10-06</i></p> <p>9. AGE (in years last birthday) <i>65</i></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY —</p>	
<p>11. BIRTHPLACE (State or foreign country) <i>Virginia</i></p>		<p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i></p>	
<p>13. FATHER'S NAME <i>David Tobias</i></p>		<p>14. MOTHER'S MAIDEN NAME <i>Evalena Brown</i></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i></p>		<p>16. SOCIAL SECURITY NO. <i>212-58-2028</i></p>	
<p>17. INFORMANT <i>James D. Smith</i></p>		<p>ADDRESS <i>1210 Riggs Ave.</i></p>	
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>(A) IMMEDIATE CAUSE <i>uremic Coma</i> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <i>Renal Failure</i> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <i>congestive Heart Failure</i></p>	
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <i>YES</i></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or out of home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <i>8-15-1972</i> to <i>8-16-1972</i> that (I) (we) last saw the deceased alive on <i>8-16-1972</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>J. H. Siddiqui</i></p>		<p>23B. DATE SIGNED <i>8-16-72</i></p>	
<p>23C. PHYSICIAN'S NAME (Type) <i>J. H. Siddiqui</i></p>		<p>23D. ADDRESS <i>Lutheran Hospital</i></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i></p>		<p>24B. DATE <i>8/19/72</i></p>	
<p>24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn Cemetery</i></p>		<p>24D. LOCATION (City, town, or county) (State) <i>Mt. Winans, Maryland</i></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <i>AUG 21 1972</i></p>		<p>25B. NAME OF REGISTRAR <i>Anthony...</i></p>	
<p>25C. FUNERAL DIRECTOR <i>Charles A. Rice</i></p>		<p>ADDRESS <i>1300 Eutaw Place</i></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07954	
72 07954				M-600	
BIRTH NO.				72 07954	
1. NAME OF DECEASED (Type or Print) <u>MRS. CATHERINE MOHR</u>			2. DATE AND HOUR OF DEATH <u>Aug-19th 1972 2¹⁰ P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>602</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>EDGEWOOD NURSING HOME</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>139 N. PORT ST.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-24-91</u>	9. AGE (In years last birthday) <u>81</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Mins.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WIRER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>WESTERN ELECTRIC</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOSEPH HUBER</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE KNOW</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-22-7742</u>		17. INFORMANT <u>Mr. Arthur C. Mohr - 1502 Roundhill Rd.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>412.41 + 250.9</u> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebral Vascular Accident -</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Cardio-Vascular Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>General Arteriosclerosis - Senility.</u> (C) DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes Mellitus -</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>		
19A. DATE OF OPERATION <u>8/19/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/15</u> 19 <u>72</u> to <u>8/19</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/19</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Anthony F. Carozza</u>				23B. DATE SIGNED <u>8/19/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Anthony F. Carozza</u>				23D. ADDRESS <u>5217 York Rd Balto Md 21212</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/23/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ZION LUTHERAN CHURCH Cem</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO., MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 21 1972</u>		25B. NAME OF REGISTRAR <u>Lindsey Robinson</u>	
25C. FUNERAL DIRECTOR <u>Stanley Miller</u>		25D. ADDRESS <u>2334 Jefferson St.</u>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. 71-01788

1. NAME OF DECEASED (Type or Print) GARRETT ANTONIO BUTLER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 18 72 7:30A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 18 72 7:30 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 2-2-71		10. AGE (in years lost birthday) 1	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Christine Butler		ADDRESS 2615 Greenmount Avenue	
15. MOTHER'S MAIDEN NAME Christine Simmons		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Craniocerebral Trauma DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	

20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Yard		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2615 Greenmount Avenue	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 7 12 72 9:30A. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Was pushed or fell from 3rd fl. window	

23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE <i>W P Mulloy</i> EXAMINER'S NAME (Type) William P. Mulloy, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
			DATE SIGNED 8-20-72		

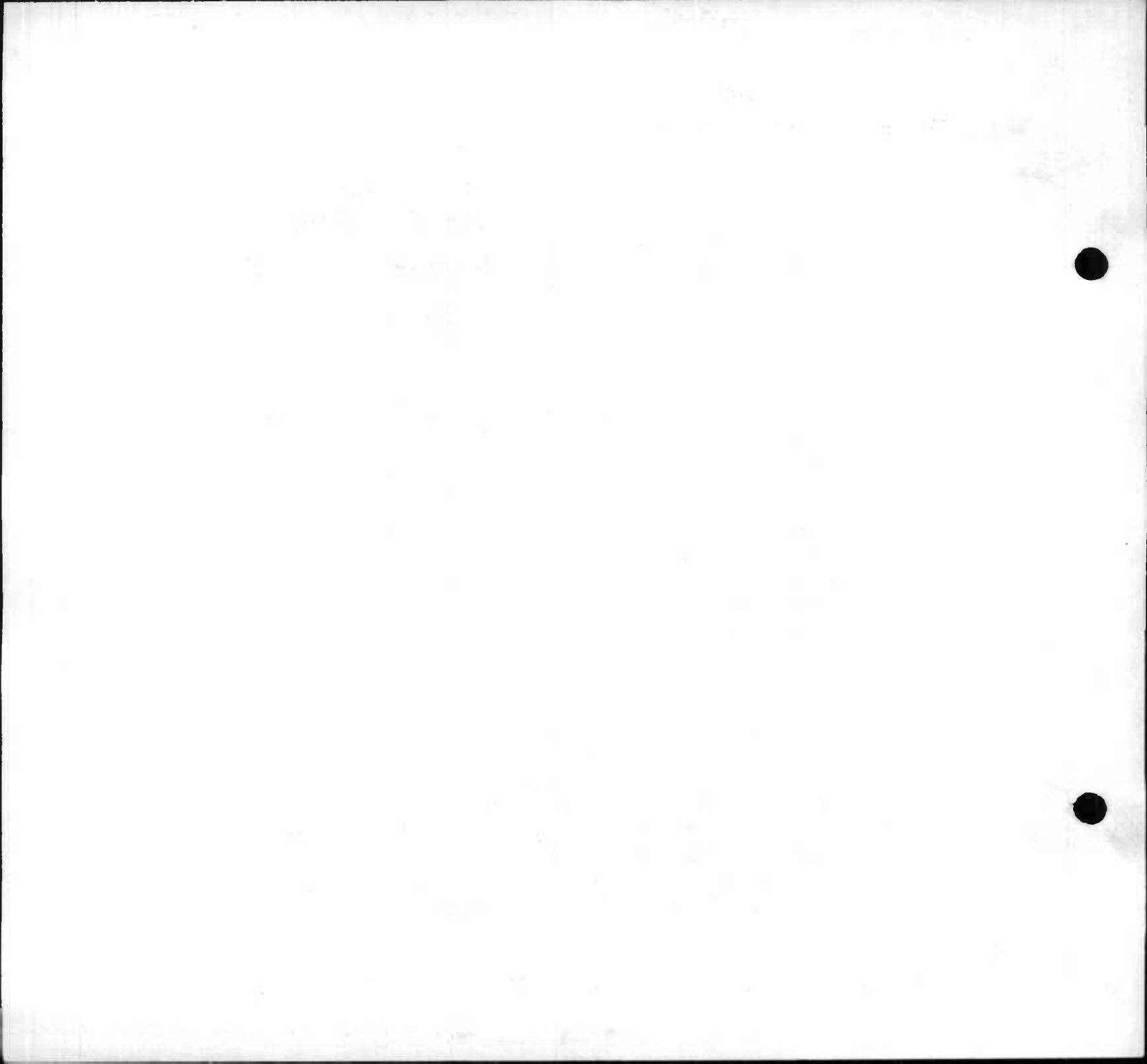
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-22-72		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR <i>Alvin B. King</i>		25C. FUNERAL DIRECTOR Wm G March		ADDRESS 928 E North Ave	

8-30-1972 - Letter from the Office of the Chief Medical Examiner - William P. Mulloy, M.D.
Assistant Medical Examiner

HRS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

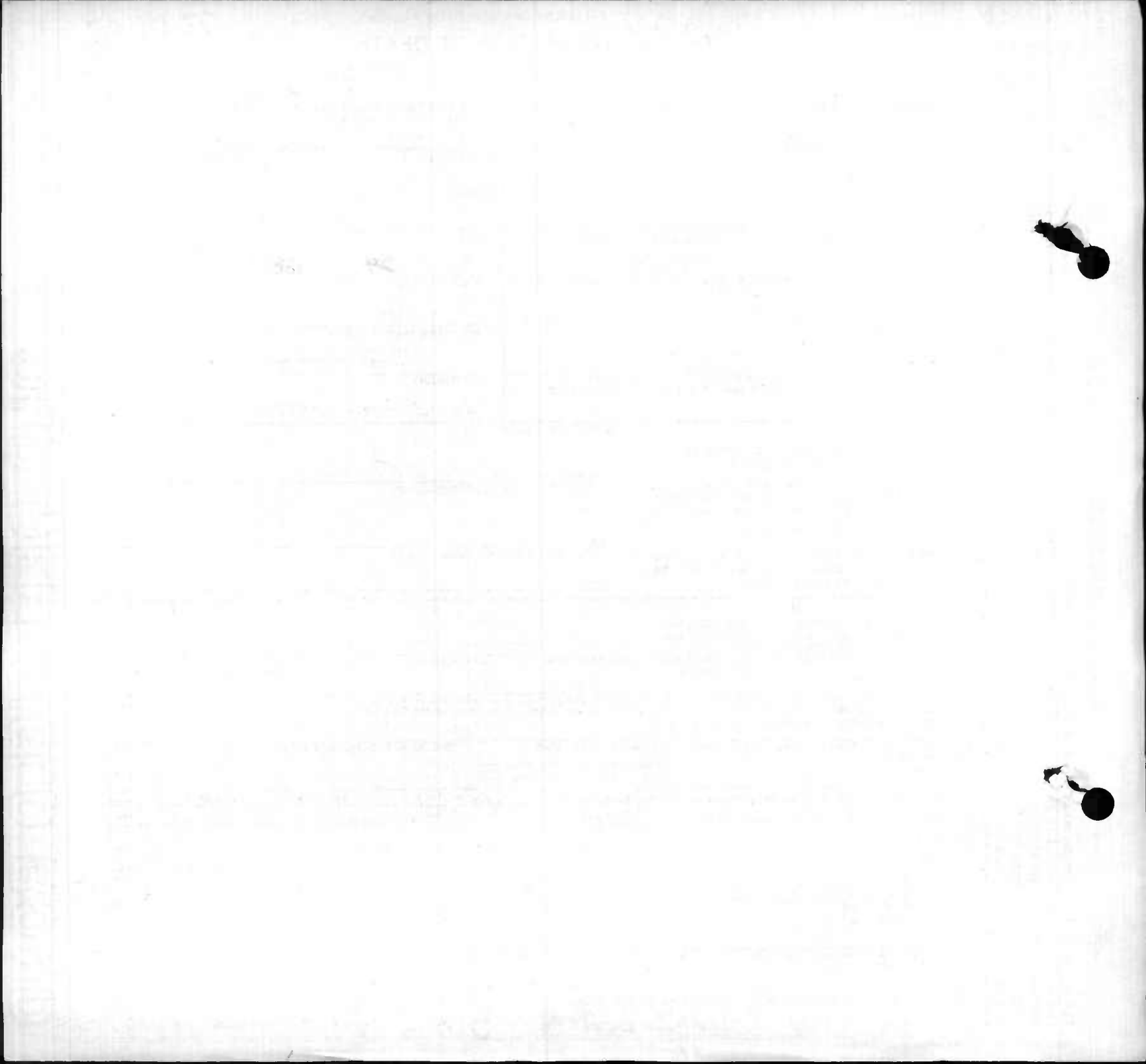
E-425		72 07956		BALTIMORE CITY HEALTH DEPARTMENT		72 07956	
BIRTH NO.				REG. NO. STATE OF MARYLAND-DUNE			
1. NAME OF DECEASED (Type or Print) <u>ELLISON, Willie</u>				2. DATE AND HOUR OF DEATH <u>8-18-72</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>The Good Samaritan Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>908</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>45</u>				C. CITY OR TOWN <u>Balto. Md.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>B</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>9-20-14</u>		9. AGE (In years last birthday) <u>57</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PREACHER</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S. C.</u>	
13. FATHER'S NAME <u>JOHN ELLISON</u>				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>248-26-3678</u>		17. INFORMANT ADDRESS <u>MARIE ELLISON 1037 CASTLE ST.</u>	
18. <u>4-3-19</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PNEUMONIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
				(B) <u>ASPIRATION</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>1 wk</u>	
				(C) <u>EVA</u>		<u>1 yr</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Recurrent Pulmonary Embol</u>						<u>2 months</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> 19 <u>72</u> to <u>Aug 18</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Aug 18</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>S. D. Wright MD</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Aug 18 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>S. D. Wright MD</u>				23D. ADDRESS <u>1810C MARCH 928 E. NORTH AVE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-22-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>BAALTO., MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 21 1972</u>		25B. NAME OF REGISTRAR <u>Indy W. Horton</u>		25C. FUNERAL DIRECTOR <u>1810C MARCH</u>		ADDRESS <u>928 E. NORTH AVE</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07957
CERTIFICATE OF DEATH				REG. NO. 72 07957
STATE OF MARYLAND-DHMH				6 A M.
1. NAME OF DECEASED (Type or Print) <u>Reese, MARIE</u>		2. DATE AND HOUR OF DEATH <u>8/19/72</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Dolphin MARYLAND, Balt.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND Gen Hospital</u>		C. CITY OR TOWN <u>Balto</u>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>501 Dolphin</u>		<u>1701</u>		
5. SEX <u>F</u>	6. RACE <u>B</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-19-04</u>	9. AGE (In years last birthday) <u>68</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>				
13. FATHER'S NAME <u>DAVID CORBIN</u>		14. MOTHER'S MAIDEN NAME <u>3 CORBIN FANNIE STOKES</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>CASSIE CHAPMAN 306 E. 21st ST</u>
18. <u>4-36-9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CVA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 NO</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CVA</u>		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CVA</u>				
19A. DATE OF OPERATION <u>NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NONE</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>7/15/72</u> 19 <u>72</u> to <u>8/19</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/19</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>A. Brucker MD</u>				23B. DATE SIGNED <u>8/19/72</u>
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-23-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>MH. CALVARY CEM.</u>
24D. LOCATION (City, town, or county) (State) <u>ANNE ARUNDEL CTY., MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 21 1972</u>		
25B. NAME OF REGISTRAR <u>Anthony [unclear]</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm C. MARCH 928 E North Ave</u>		

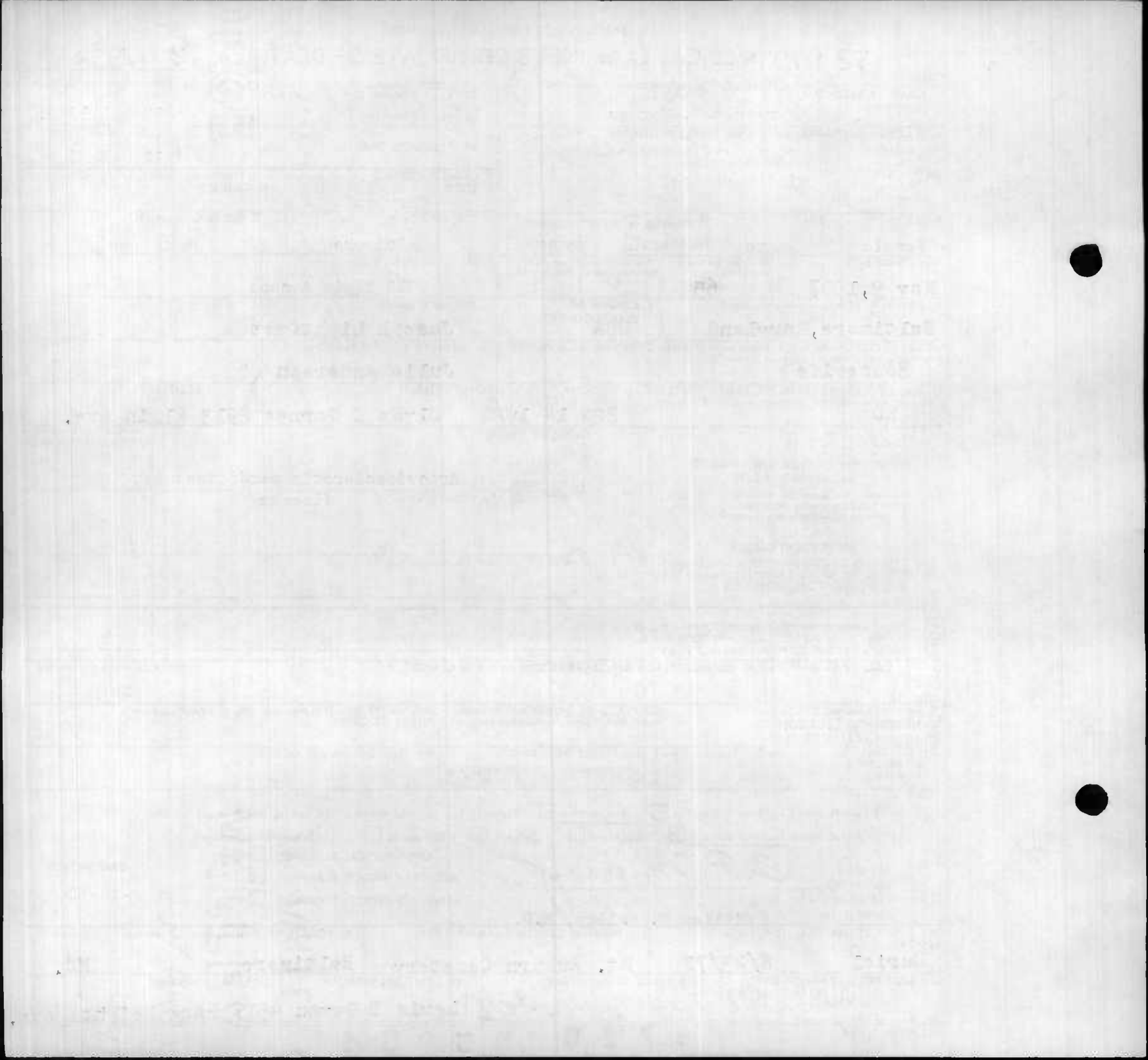


72 0795 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07958

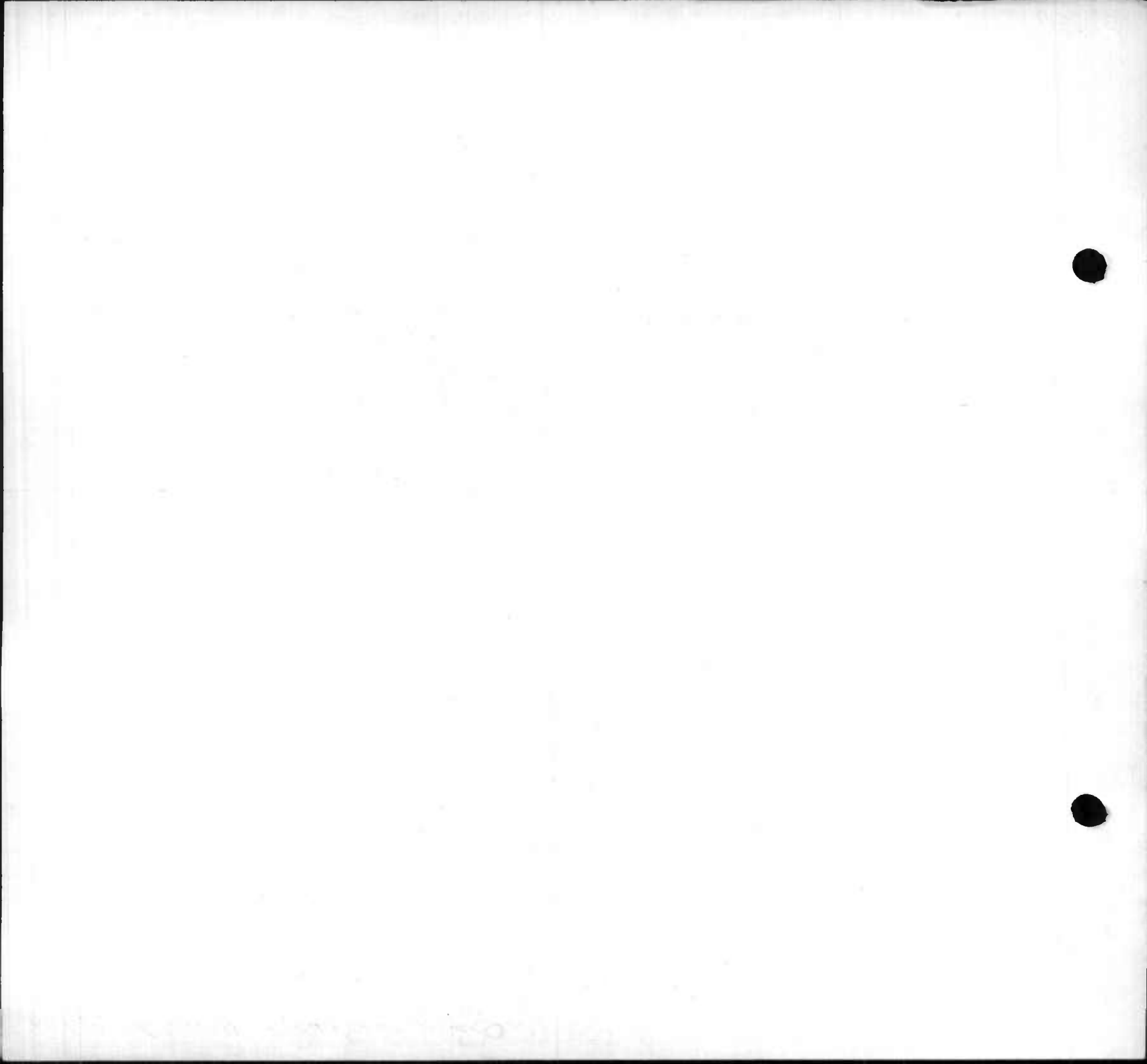
BIRTH NO. STATE OF MARYLAND - DHMH

1. NAME OF DECEASED (Type or Print) Margaret V. Garnes		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 8 19 72 1:35 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital		3. DATE PRONOUNCED DEAD Month Day Year 8 19 72 1:35 P.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH May 9, 1907		10. AGE (In years lost birthday) 65	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Julia Anderson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 220 14 1020	
18. INFORMANT Clyde C Garnes		ADDRESS 2913 Elgin Ave.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: disease	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
22. DATE OF OPERATION		23. CONDITION FOR WHICH OPERATION WAS PERFORMED	
24. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
26. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		27. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
28. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		29. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/23/72	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR Audrey Whitton	
25C. FUNERAL DIRECTOR Lewis T Gwynn		ADDRESS 4517 Park Heights Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

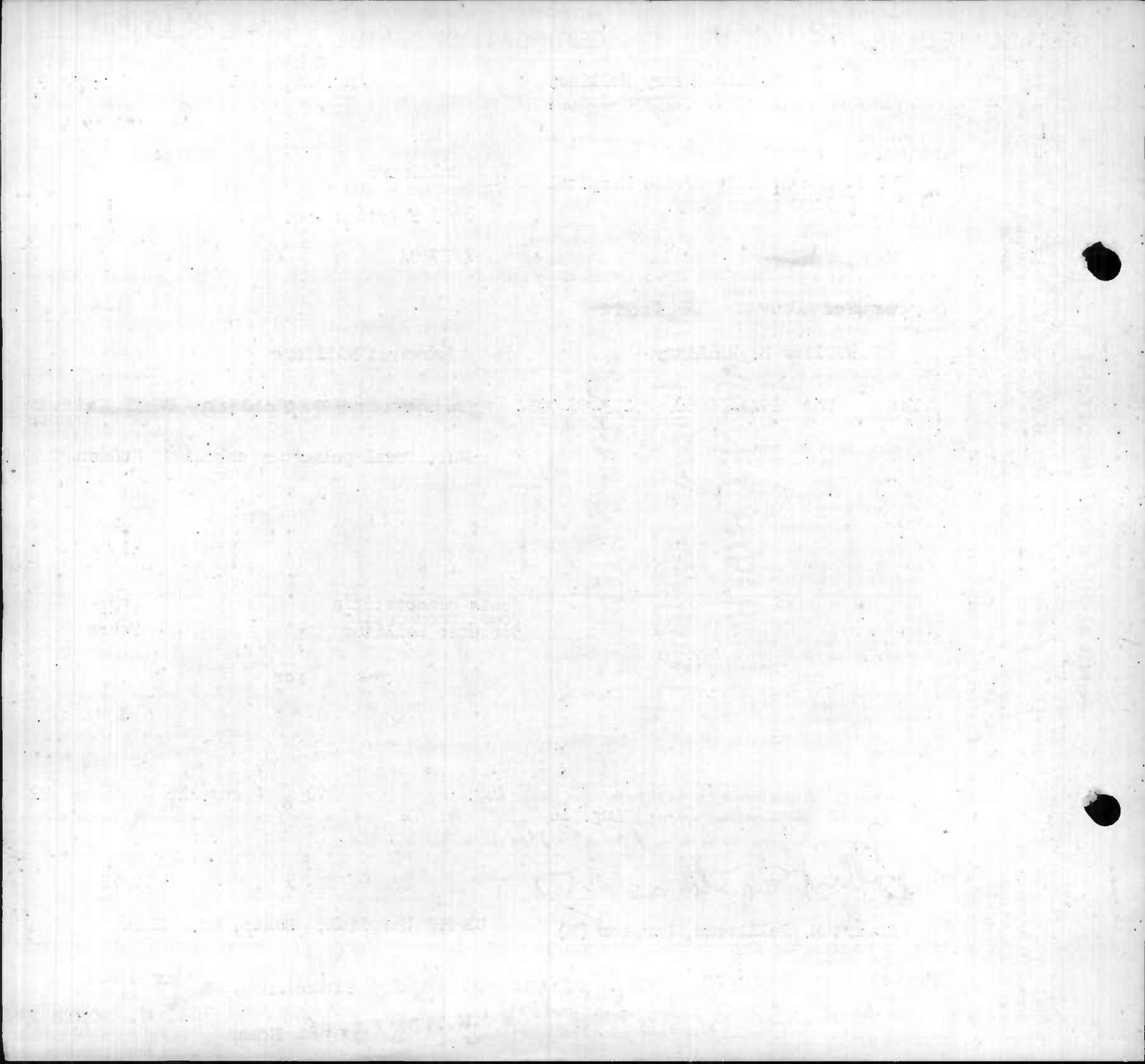
BIRTH NO. 72 07959		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07959	
1. NAME OF DECEASED (Type or Print) FRIES, CHARLES W.		2. DATE AND HOUR OF DEATH 8.20.72 12.50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY MD.135 W. Randall St. 2303			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SOUTH BALTIMORE GENERAL HOSPITAL		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 135 W. RANDALL ST. 2/230					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-14-01	9. AGE (In years last birthday) 70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired. Upholstery		10B. KIND OF BUSINESS OR INDUSTRY Private Business.		11. BIRTHPLACE (State or foreign country) Va. Winchester	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jacob S. Fries (Dec.)		14. MOTHER'S MAIDEN NAME Buelah? (Dec) WILLEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-03-0723-A		17. INFORMANT Brought in By Ambulance D.O.A.	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE ? Acute M.I.			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) A.S.C.V.D.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Atrial Fibrillations.			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N.A.		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-8-1972 to 7-22-1972 that (I) (we) last saw the deceased alive on 7-22-1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 8.20.72	
23C. PHYSICIAN'S NAME (Type) D.S. SAWHNEY		23D. ADDRESS 3001 S. Hanover St. Baltimore Md 21225			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1972 Aug 23-72		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cmn.	
24D. LOCATION (City, town, or county) (State) Brooklyn B.D. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972			
25B. NAME OF REGISTRAR Sydney H. [Signature]		25C. FUNERAL DIRECTOR CURTIS E. EVANS 1400 S. CHARLES ST 21230			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 07960</u>	
72 07960 STATE OF MARYLAND - DHMH				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>William Henry Holliday</u>			2. DATE AND HOUR OF DEATH <u>Aug. 16, 1972</u> <u>1:05 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>US Public Health Service Hospital</u> <u>3100 Wyman Pkwy.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1538</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3603 Fairview Ave.</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/27/04</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>career Serviceman</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		
11. BIRTHPLACE (State or foreign country) <u>Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>William H. Holliday</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Williams</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>USA 1941-1960</u>			16. SOCIAL SECURITY NO. <u>213-07-0084</u>		
17. INFORMANT <u>Mrs. Barbara F. Holliday</u>			ADDRESS <u>3603 Fairview</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Multifocal pulmonary emboli</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute pancreatitis</u> <u>Focal pneumonitis</u> <u>Diabetes mellitus</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Days</u> <u>Days</u> <u>Years</u>		
19A. DATE OF OPERATION <u>Aug. 9</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>yes</u>		
20A. AUTOPSY? (Yes or No) <u>yes</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>yes</u>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>Aug. 16</u> <u>1972</u>		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? <u>yes</u>		
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>Aug. 9</u> <u>1972</u> to <u>Aug. 16</u> <u>1972</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>Aug. 16</u> <u>1972</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert E. Belliveau</u>			23B. DATE SIGNED <u>8/17/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>Robert E. Belliveau, Surgeon (R)</u>			23D. ADDRESS <u>US PHS Hospital, Balto, Md. 21211</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>8-22-72</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>Garden of Eternal Hope</u>			24D. LOCATION (City, town, or county) (State) <u>Finksburg, Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 21 1972</u>			25B. NAME OF REGISTRAR <u>Andrew W. ...</u>		
25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME</u>			ADDRESS <u>3035 W. NORTH AVE</u>		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07961

BIRTH DATE

1. NAME OF DECEASED
(Type or Print)

KEVIN TOWSON

2. DATE
OF
DEATHKnown ☒
Estimated ☐

Month

Day

Year

Hour

August 16, 1972

4:15 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

August 16, 1972

4:15 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

1510

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

7-9-1969

10. AGE (In years
last birthday)

3

11. Under 1 Yr. 11 Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

4005 Oakford Avenue

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Arthur R. Towson

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

child

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Doretha Terry

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mr. Arthur Towson 4005 Oakford Ave.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Cerebro-cranial injuries

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Oakford St. E. of Granada Avenue

22D. TIME
OF INJURY
(APPROX.)

8-13-72

3:20 P.m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Marvin S. Platt, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 17, 1972

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-19-1972

24C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

24D. LOCATION

(City, town, or county)

(State)

Baltimore

Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 21 1972

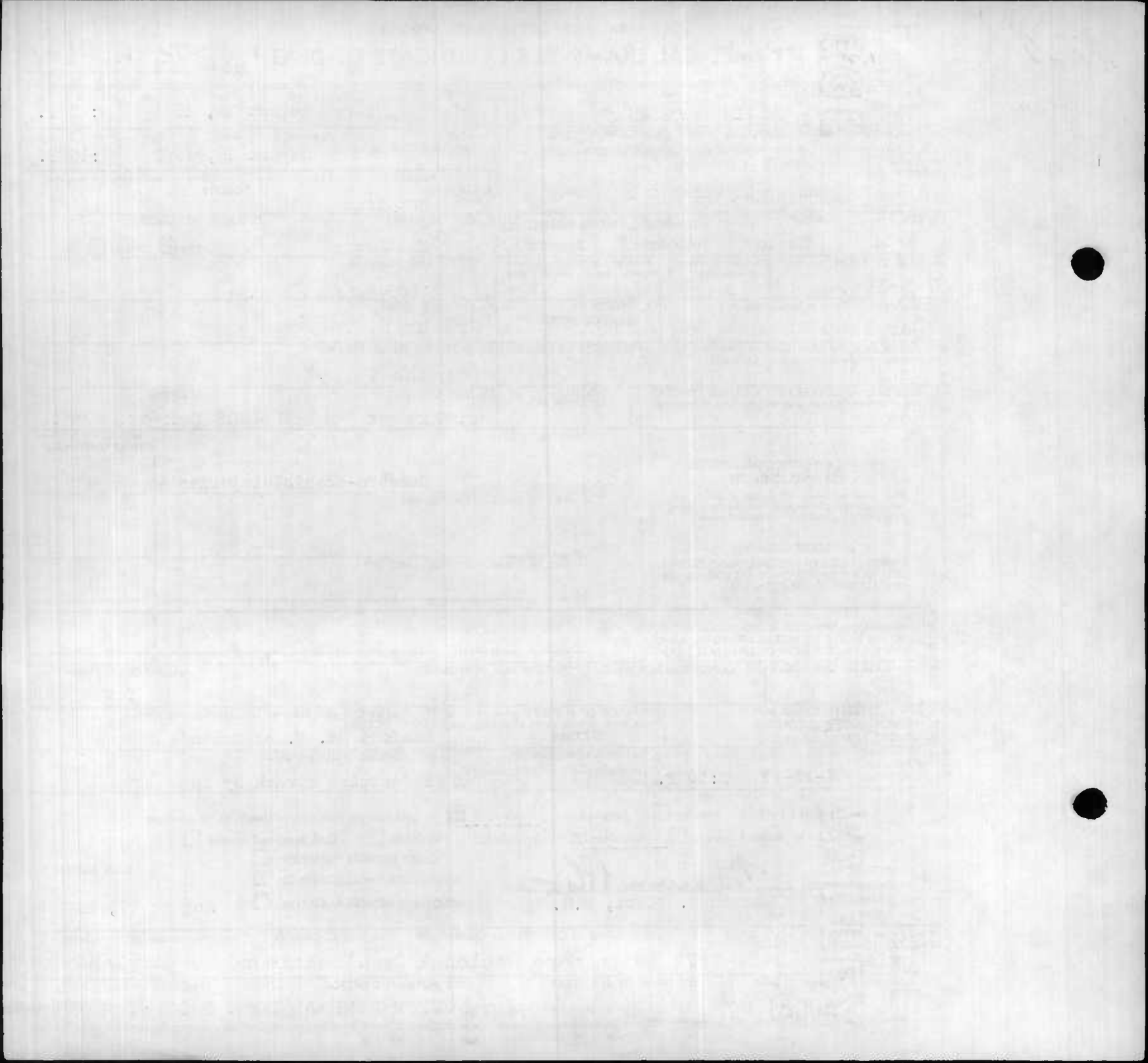
25B. NAME OF REGISTRAR

Sidney B. Weston

25C. FUNERAL DIRECTOR

ADDRESS

NUTTER FUNERAL HOME 3035 W. NORTH AVE



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07962	
72 07962 CERTIFICATE OF DEATH					
BIRTH NO. 72 07962		STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print) Hollman, Arthur		2. DATE AND HOUR OF DEATH 8/13/72 11:37 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Md Hospital 38		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 714 1/2 W. Saratoga Street			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-1912	9. AGE (In years last birthday) 60	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) South Carolina	
13. FATHER'S NAME Isaac Nelson		14. MOTHER'S MAIDEN NAME Sara Hollmon			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-09-3985		17. INFORMANT Mrs. Edna Hunter ADDRESS 2240 Manse Street Columbia, S. C.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Probable Ca of Lung w/ probable metastatic lesion to brain		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Suspected TB					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/25/72 19 to 8/13/72 19 that (we) last saw the deceased alive on 8/13/72 @ 12:30 p.m. 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mark H. Kasowitz DEGREE MD				23B. DATE SIGNED 8/13/72	
23C. PHYSICIAN'S NAME (Type) MARK H. KASOWITZ				23D. ADDRESS UNIVERSITY HOSPITAL, BALTO. MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-18-72		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION Baltimore		24E. STATE Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR Edna Hunter		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE.	

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CERTIFICATE OF DEATH

BIRTH NO. 72 07963
STATE OF MARYLAND - DHMH1. NAME OF DECEASED
(Type or Print)

BROGDEN, EDITH MARIE

2. DATE AND HOUR OF DEATH

SEPTEMBER 14, 1972

8:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED OEO

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)40 ST. AGNES HOSPITAL
WILKENS & CATON AVENUES
BALTIMORE, MARYLAND 21229

4. USUAL RESIDENCE OF DECEASED LIVED, IF INSTITUTION: residence before admission)

A. STATE

B. COUNTY

MARYLAND

AA CO.

C. CITY OR TOWN

HANOVER

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

BOX 39-B - ROUTE 2

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

03 08 96

9. AGE (In years
last birthday)

76

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MAID

10B. KIND OF BUSINESS OR INDUSTRY

UNIVERSITY HOSP.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

JOHN H. NOAKES

14. MOTHER'S MAIDEN NAME

LAVINIA MATTHEWS

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

MRS. LAVERNA JONES RT. 2 BOX 39-B

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

CA Sigmoid colon

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

8/9/72

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Relief total obstruction sigmoid

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ☒ (this hospital) attended the deceased from AUGUST 8, 19 72 to AUGUST 14, 19 72.
that ☒ (we) lost saw the deceased alive on AUGUST 14, 19 72 and that ☒ (our) opinion death occurred on the date
and hour and from the causes stated above. ☒ (We) (did) ☒ view the body after death.

23A. SIGNATURE

Dr. Le Roy Buckler

M.D.
DEGREEAttending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Type)

DR. LE ROY BUCKLER

23D. ADDRESS

BALTIMORE, MD. 21229
ST AGNES HOSPITAL-WILKENS & CATON AVE.24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

8-18-72

24C. NAME OF CEMETERY or CREMATORY

BALTIMORE NATIONAL CEM. BALTIMORE

24D. LOCATION

(City, town, or county)

MARYLAND

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 21 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

NUTTER FUNERAL HOME 3035 W. NORTH AVE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RECEIVED, SOUTH MOUNTAIN
JANUARY 1, 1952

MAILED 10
JAN 1 1952

UNITED STATES DEPARTMENT OF THE ARMY
WASHINGTON, D. C. 20315

TO: THE SECRETARY OF THE ARMY
FROM: THE CHIEF OF THE ARMY

SUBJECT: ARMY REGULATION NO. 1-10
DATE: JANUARY 1, 1952

1. The purpose of this regulation is to provide for the proper management of the Army's resources.

2. This regulation applies to all members of the Army and to all Army property.

3. The following are the major principles which govern the management of Army resources:

a. Economy in the use of resources.

b. Efficiency in the use of resources.

c. Accountability for resources.

d. Conservation of resources.

e. Protection of resources.

f. Proper disposition of resources.

4. This regulation is effective on the date of its issuance.

5. The Secretary of the Army is authorized to issue such orders and regulations as may be necessary to carry out the provisions of this regulation.

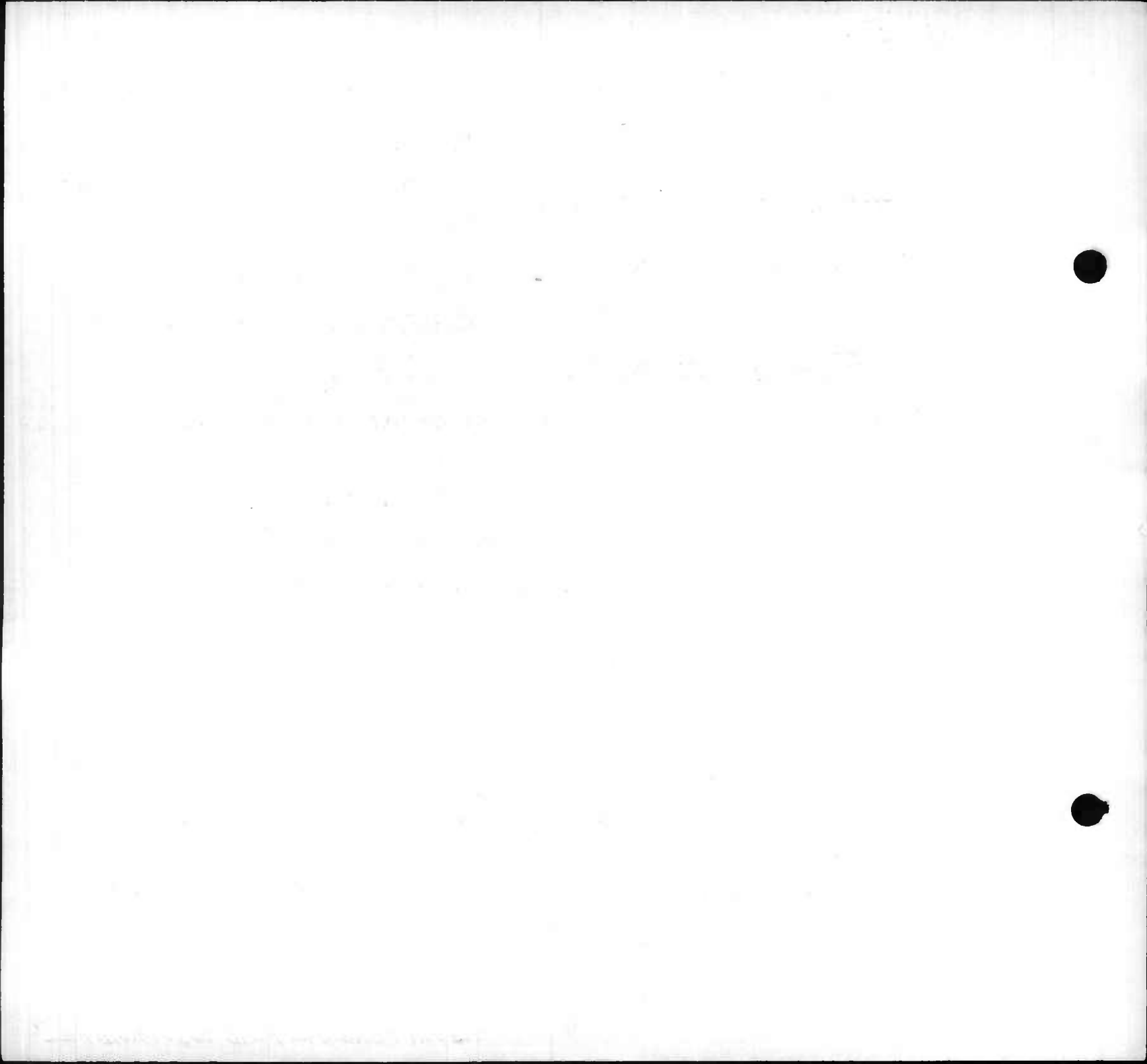
6. This regulation is subject to the approval of the Joint Chiefs of Staff.

7. The Secretary of the Army is authorized to issue such orders and regulations as may be necessary to carry out the provisions of this regulation.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>W-350 72 07964</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 07964</p> <p>STATE OF MARYLAND-DHMH</p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) ANNIE WHITEN</p>		<p>2. DATE AND HOUR OF DEATH 8/19/72 4:20 A.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Scnai Hosp. of Baltimore</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE Maryland B. COUNTY 2802</p> <p>C. CITY OR TOWN Baltimore City D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 5321, Liberty Heights Ave.</p>	
<p>5. SEX F</p>	<p>6. RACE Ngr</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 9-13-89 9. AGE (in years last birthday) 83 1/2</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (State or foreign country) BALTIMORE, Md</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME PERRY JOHNSON</p>		<p>14. MOTHER'S MAIDEN NAME UNKNOWN</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown</p>		<p>16. SOCIAL SECURITY NO. Unknown</p>	
<p>17. INFORMANT MRS. ANN JONES</p>		<p>ADDRESS MR. HARRY WHITEN - 5321 LIBERTY HEIGHTS AVE</p>	
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio pulmonary arrest</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: Constrictive chest furniture</p> <p>(C) Arterio Sclerotic heart disease.</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months</p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 8/19/72 to 8/19/72 that (I) (we) last saw the deceased alive on 8/19/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Sudhindra</p>		<p>23B. DATE SIGNED 8/19/72</p>	
<p>23C. PHYSICIAN'S NAME (Type) R. SUDHINDRA</p>		<p>23D. ADDRESS Scnai Hosp. of Baltimore</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL</p>		<p>24B. DATE 8/23/72</p>	
<p>24C. NAME OF CEMETERY or CREMATORY ST. THOMAS CEM.</p>		<p>24D. LOCATION (City, town, or county) (State) RANDALSTOWN, Md.</p>	
<p>25A. DATA RECD BY HEALTH DEPT. AUG 21 1972</p>		<p>25B. NAME OF REGISTRAR Sudhindra</p>	
<p>25C. FUNERAL DIRECTOR GIBSON FUNERAL HOME</p>		<p>ADDRESS 1631 PRUID HILL</p>	



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72 07965

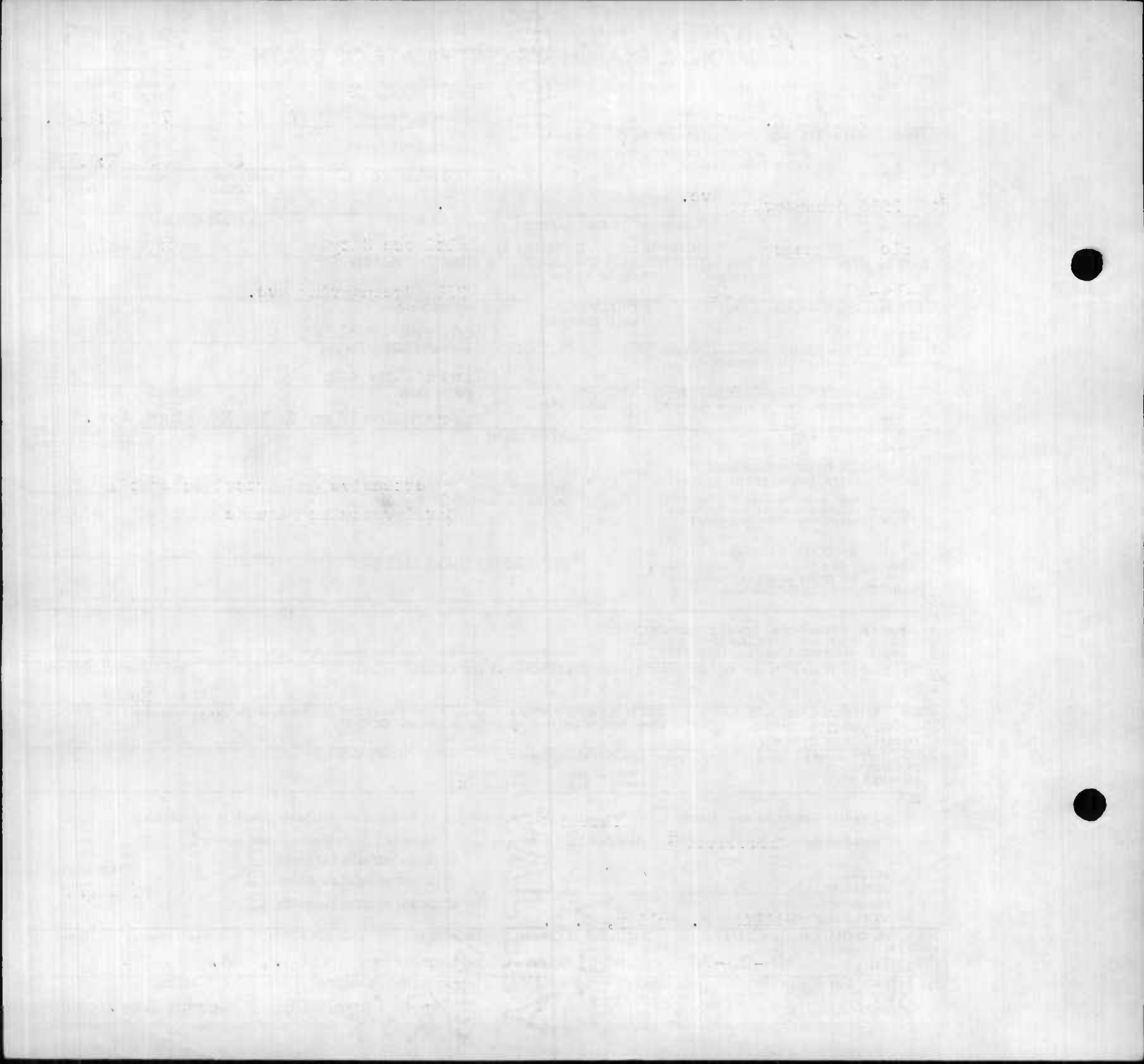
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07965

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES E. MOULDEN				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 18 72 2:15 P. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 3516 Greenspring Ave.				3. DATE PRONOUNCED DEAD Month Day Year Hour 8 18 72 2:15 P. M.			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1512				C. CITY OR TOWN Baltimore City			
6. SEX male				7. RACE negro			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH 3-14-21		10. AGE (In years last birthday) 51		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Rodgers Moulden		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Clara Johnson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII	
17. SOCIAL SECURITY NO.		18. INFORMANT Warren Moulden		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>W P Mulloy</i> M.D. EXAMINER'S NAME (Type) William P. Mulloy, M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/ 20/72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-23-72		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR <i>Aditya</i>		25C. FUNERAL DIRECTOR ADDRESS Wm C March 928 E North Ave.			



N-350

72 07966 STATE OF MARYLAND - DEPT
BALTIMORE CITY HEALTH DEPARTMENT

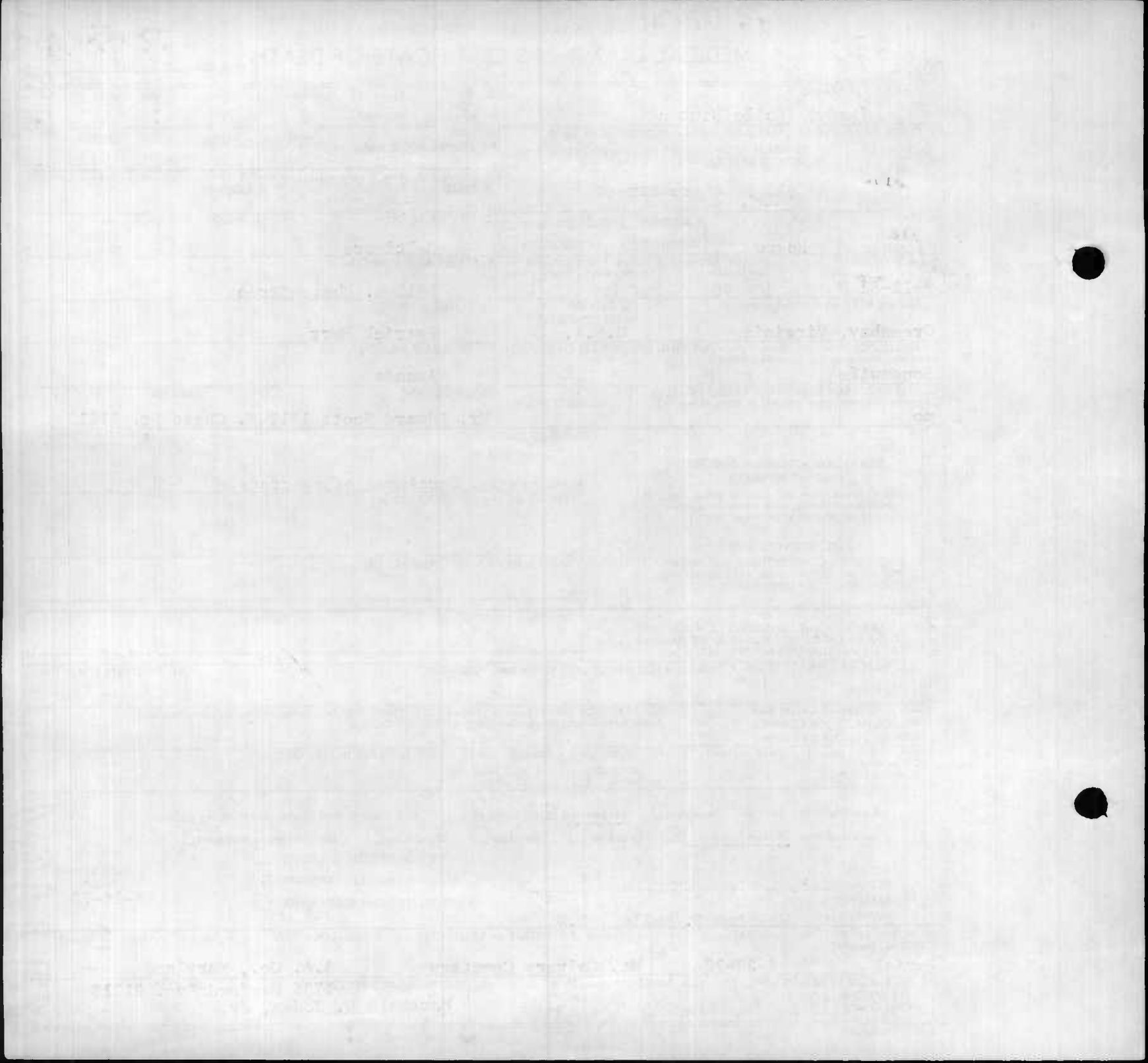
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07966

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) (Lady) Belle Newton		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 18 72 6:20 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1812 E. Chase Street		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 18 72 6:20 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 808			
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 9-12-81		10. AGE (In years lost birthday) 90	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) Greenbay, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	E. STREET AND NUMBER 1812 E. Chase Street
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY	13. FATHER'S NAME Patrick Hurt
15. MOTHER'S MAIDEN NAME Amanda			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	18. INFORMANT ADDRESS Mr. Edward Scott 1812 E. Chase St. 21213
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE Carcinoma of pancreas DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION			21. AUTOPSY? (Yes or No) No
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>W P Mulloy</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) William P. Mulloy, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8-18-72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-22-72	24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery	24D. LOCATION (City, town, or county) (State) A.A. Co., Maryland
25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972	25B. NAME OF REGISTRAR <i>Sidney L. Houston</i>	25C. FUNERAL DIRECTOR 735 Harford Ave. 21213 Marshall W. Jones, Jr.	



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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07967

REG. NO.

BIRTH NO. 72-04151

1. NAME OF DECEASED (Type or Print) TROY BRIDGEN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour June 6, 1972 9:47 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 901			
6. SEX M Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 2-29-72		10. AGE (In years last birthday) 3	E. STREET AND NUMBER 917 Cator Avenue
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME Alton Bridgen
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME Pandora Phillips
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	18. INFORMANT ADDRESS

MEDICAL CERTIFICATION	19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E988X		CAUSE OF DEATH Craniocerebral Injuries		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unk.		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Unk.	
22D. TIME OF INJURY (APPROX.) Unknown		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Battered child	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/8/72					
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 8-16-72		24C. NAME OF CEMETERY or CREMATORY Med. Ex. office	
24D. LOCATION (City, town, or county) (State) 111 Penn St. Balt MD		25A. DATE REC'D BY HEALTH DEPT. AUG 21 1972		25B. NAME OF REGISTRAR Andrew L. Hinton	
25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		25D. ADDRESS			

Sex is male, per Evelyn Rogers call to hospital
H.B.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07968

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Viola Nagle		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 8 20 72 Hour 9:25 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 20 72 9:25 A. M.	
6. SEX Female		7. RACE White Female	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Maryland B. COUNTY BALTO C. CITY OR TOWN Catonsville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH 7-15-1907		10. AGE (In years last birthday) 65	
11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WALTER O. NAGLE		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESWOMEN	
15. MOTHER'S MAIDEN NAME EMMA MORRIS		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. A 215-05-8142		18. INFORMANT MRS. ETHEL KEMP	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-20-72	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-23-72	
24C. NAME of CEMETERY or CREMATORY LODGE PARK		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR Sidney Whitman	
25C. FUNERAL DIRECTOR WEDER FUNERAL		ADDRESS HOME 5311 EDMONDSON AVE	

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FUNERAL DIRECTOR: IMPORTANT

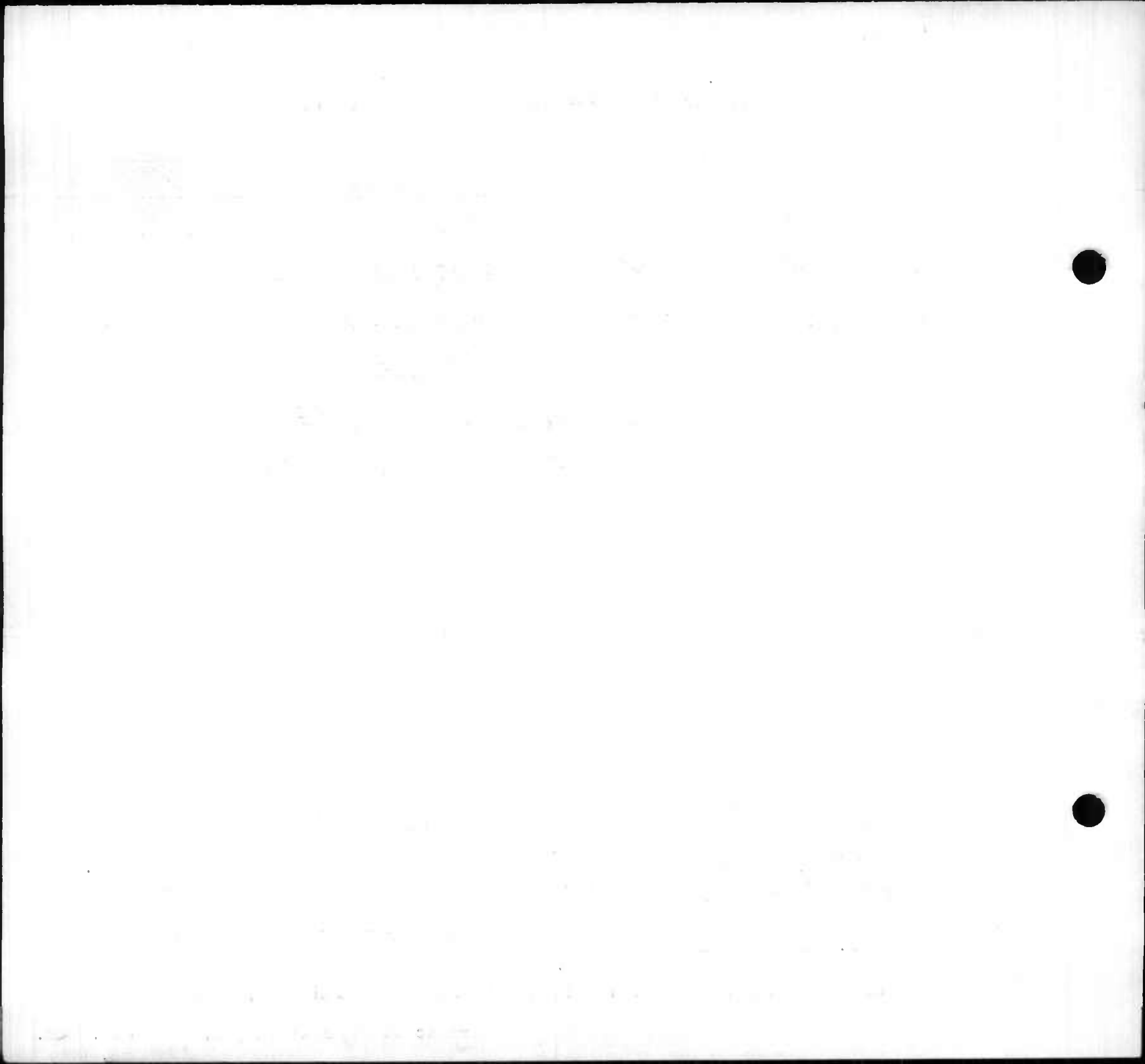
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07969	
CERTIFICATE OF DEATH				REG. NO. 72 07969	
BIRTH NO. S-620		1. NAME OF DECEASED (Type or Print) Amalia A. Sorge			
2. DATE AND HOUR OF DEATH 8/18/72		6:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE md		B. COUNTY 2758	
5813 Willowton Ave		C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 5813 Willowton Rd Ave					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 10, 1880	9. AGE (In years last birthday) 91	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME August Steinert		14. MOTHER'S MARDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-57404-T		17. INFORMANT Rhoda Sorge ADDRESS Same	
18. 4/2-21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE AS HCD - ch failure			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral Thrombosis vent. Small Nephroses - c uremia Stroke			
(C) Genil arteriosclerosis					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/1/72 19 72 8/18 19 72 that (I) (✓) last saw the deceased alive on 8/16 19 72 and that in (my) (or) opinion death occurred on the date and hour and from the causes stated above. (I) (✓) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. W. Mintz DEGREE				23B. DATE SIGNED 8/18/72	
23C. PHYSICIAN'S NAME (Type) DONALD W. MINTZ DEGREE				23D. ADDRESS 3009 EVERGREEN AVE BALTO MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE Aug 19, 1972		24C. NAME OF CEMETERY or CREMATORY Chickwood	
24D. LOCATION (City, town, or county) Balto md		(State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR Dr. W. Mintz		25C. FUNERAL DIRECTOR Dr. W. Mintz ADDRESS 6067 Hay Rd	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

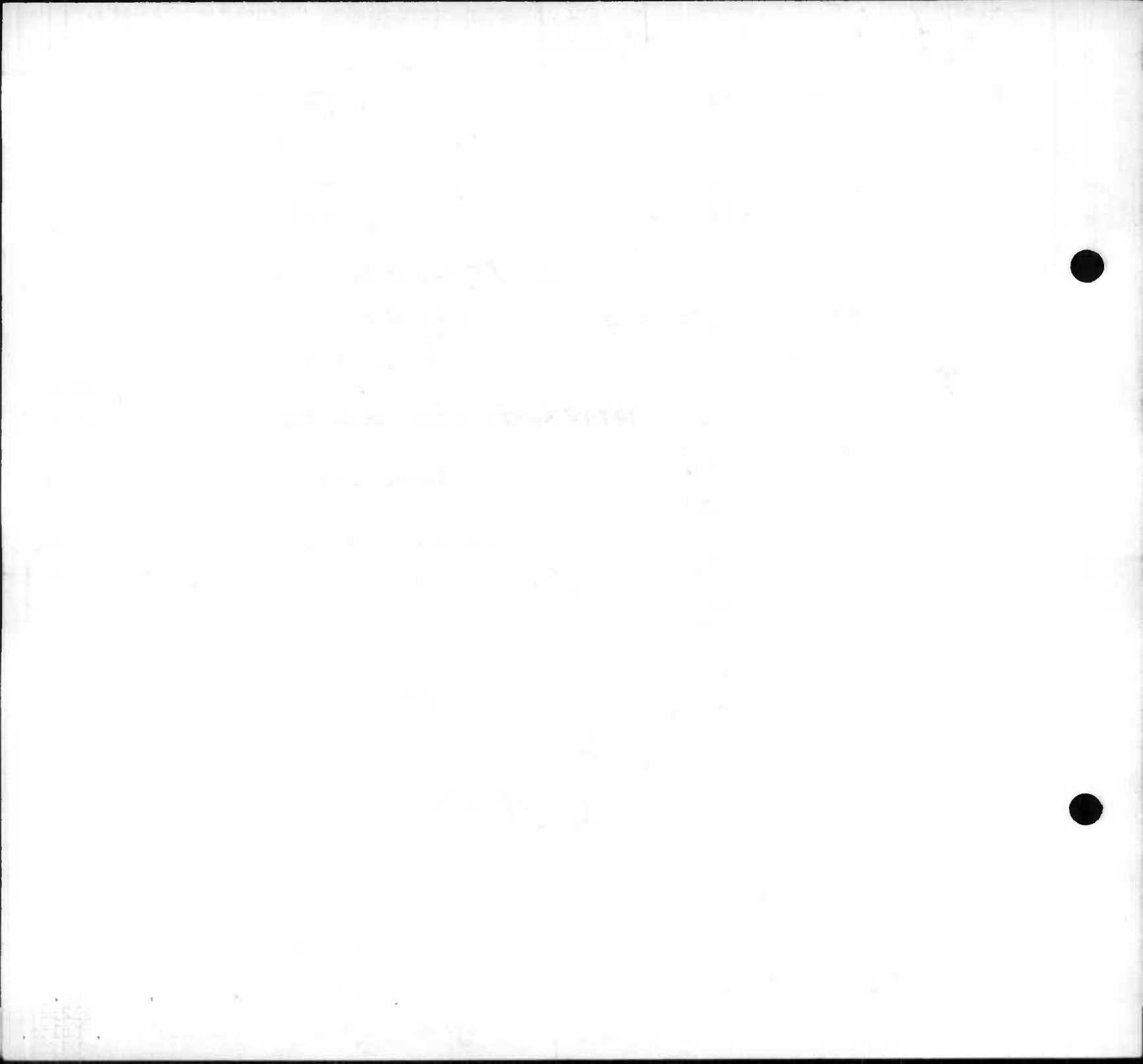
BALTIMORE CITY HEALTH DEPARTMENT				72 07970		REG. NO. 72 07970	
C-640				72 07970			
BIRTH NO.				STATE OF MARYLAND - DEPT.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
O. Georgie Carroll X Carroll				8/18/72			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE MD			
5316 GWYNN OAK AVE				B. COUNTY		2802	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG 7, 1890	
9. AGE (In years last birthday) 82		10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife						MARYLAND	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Ogle		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-43-8677		17. INFORMANT John Carroll		ADDRESS 5316 Gwynn Oak Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I BRONCHOGENIC CARCINOMA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				NONE			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> Inotify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-13-72 to 8-18-72 that (I) (we) last saw the deceased alive on 8-18-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Leon Ashman				23B. DATE SIGNED 8-18-72			
23C. PHYSICIAN'S NAME (Type) Dr. Leon Ashman				23D. ADDRESS 5907 GWYNN OAK AVE, Balto, Md. 21207			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/21/72		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR Armacost Funeral Chapel		ADDRESS 4600 Lib. Hts. Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

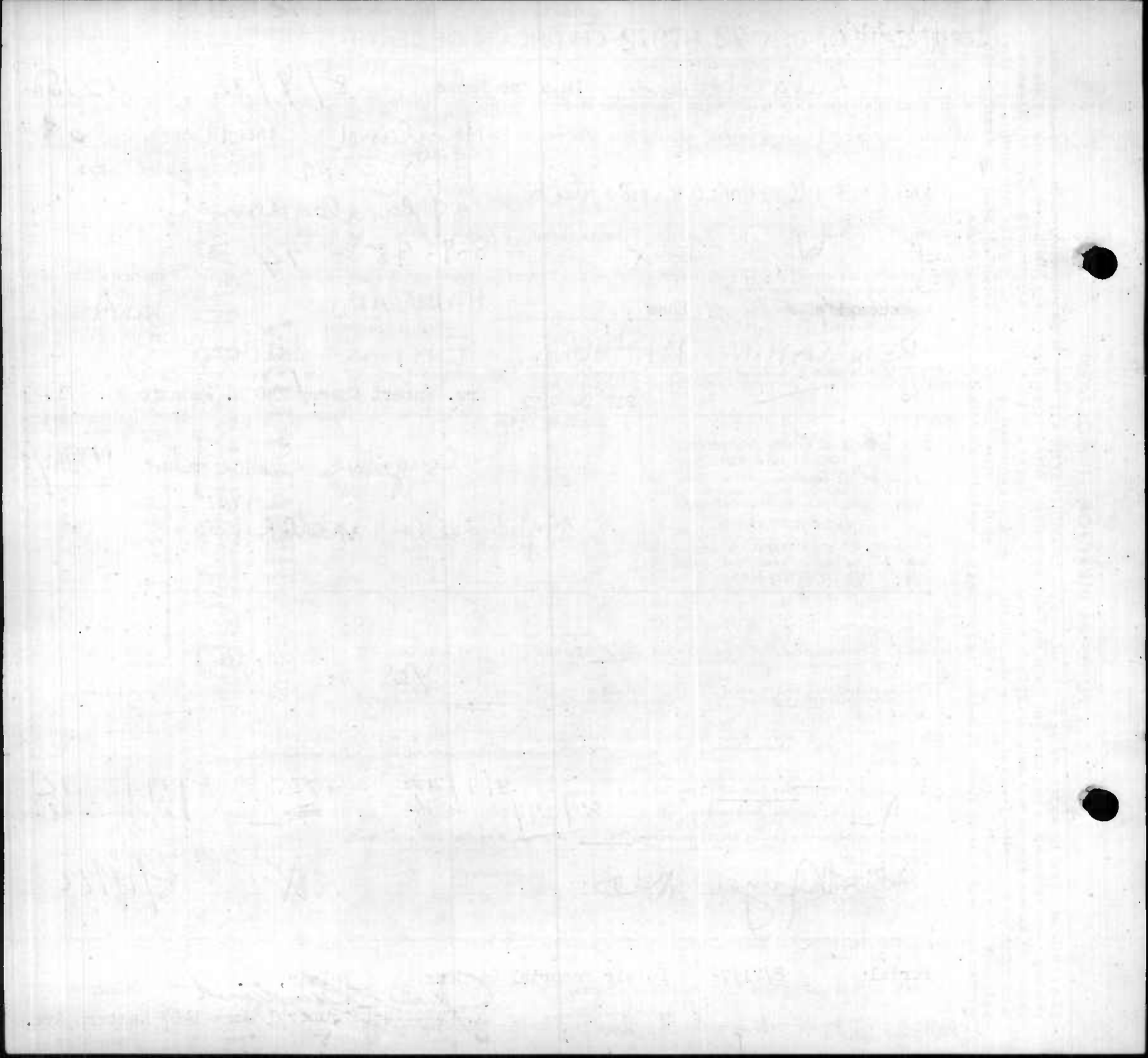
BALTIMORE CITY HEALTH DEPARTMENT				72 07971		REG. NO.		72 07971		
H-400 72 07971 CERTIFICATE OF DEATH										
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>ANNAMAE HALL</u>				2. DATE AND HOUR OF DEATH <u>8/17/72</u> <u>1:00</u> P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO</u>					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY OF MD. HOSPITAL</u> <u>BALTIMORE, MD</u>					C. CITY OR TOWN <u>WHITE MARSH</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
					E. STREET AND NUMBER <u>Box 51 VINCENT FARM LANE</u>					
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-13-22</u>	9. AGE (In years last birthday) <u>50</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>LEE W. SHUMBERGER</u>					14. MOTHER'S MAIDEN NAME <u>MARIE AHLER</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>189-18-5687</u>		17. INFORMANT <u>Leonard Hall 51 Vincent Farm Lane White Marsh</u>				
18. <u>28737</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE <u>CARDIAC ARRHYTHMIA</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>			
					(B) <u>RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>5 YEARS</u>			
					(C) <u>MICROANGIOPATHIC ANEMIA</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION <u>1</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) 1 Month () Day () Year () Hour ()			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>8/15/72</u> 19 <u>72</u> to <u>8/17</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/17/72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Kenneth V. Eden MD</u>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>8/17/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>KENNETH V. EDEN</u>					23D. ADDRESS <u>UNIV. HOSP. BALTO. MD</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>8/21/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holly Hill Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Bird River Rd. Balto. Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 22 1972</u>			25B. NAME OF REGISTRAR <u>James H. H. H.</u>			25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>			ADDRESS <u>21236 7401 Belair Rd. Balto.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

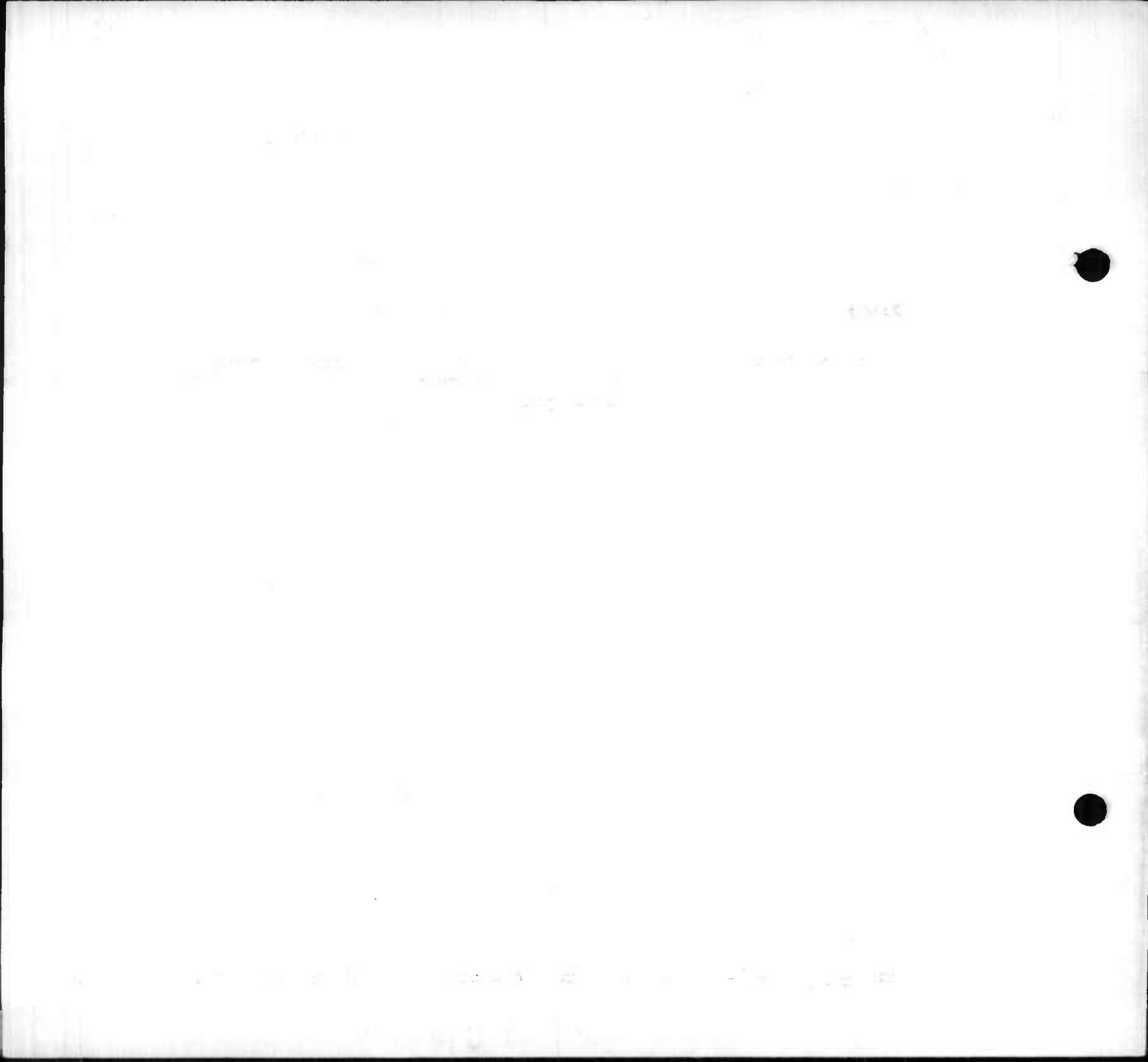
BALTIMORE CITY HEALTH DEPARTMENT				72 07972		REG. NO. 72 07972	
M-200				72 07972			
BIRTH NO.				72 07972			
1. NAME OF DECEASED (Type or Print) <u>Lula Mease</u>				2. DATE AND HOUR OF DEATH <u>8/18/72</u> <u>12:15 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>UNION Memorial hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNION Memorial hospital</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>89 Langley Road</u>							
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-9-98</u>	9. AGE (in years last birthday) <u>74</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>BEN JAMIN HAMMOND</u>				14. MOTHER'S MAIDEN NAME <u>EMMA LUMIN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212 24 9171</u>		17. INFORMANT ADDRESS <u>Mrs. Robert Cherry 240 E. Padonia Rd. 21093</u>	
18. <u>412.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Congestive cardiac failure</u> (B) <u>Hypertensive Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>8/19/72</u> 19 <u>72</u> to <u>8/19/72</u> 19 <u>72</u> that (1) (we) last saw the deceased alive on <u>8/19/72</u> 19 <u>72</u> and that (1) (our) opinion of death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>John Mayer MD</u>				23B. DATE SIGNED <u>8/19/72</u>		23C. PHYSICIAN'S NAME (Type) <u>John Mayer MD</u>	
23D. ADDRESS <u>Belair Memorial Gardens</u>				23E. ADDRESS <u>Belair, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>8/21/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Belair Memorial Gardens</u>	
24D. LOCATION (City, town, or county) (State) <u>Belair, Md.</u>							
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 22 1972</u>				25B. NAME OF REGISTRAR <u>John Mayer MD</u>		25C. FUNERAL DIRECTOR <u>Brudzinski Funeral Home</u>	
25D. ADDRESS <u>1407 Eastern Ave.</u>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

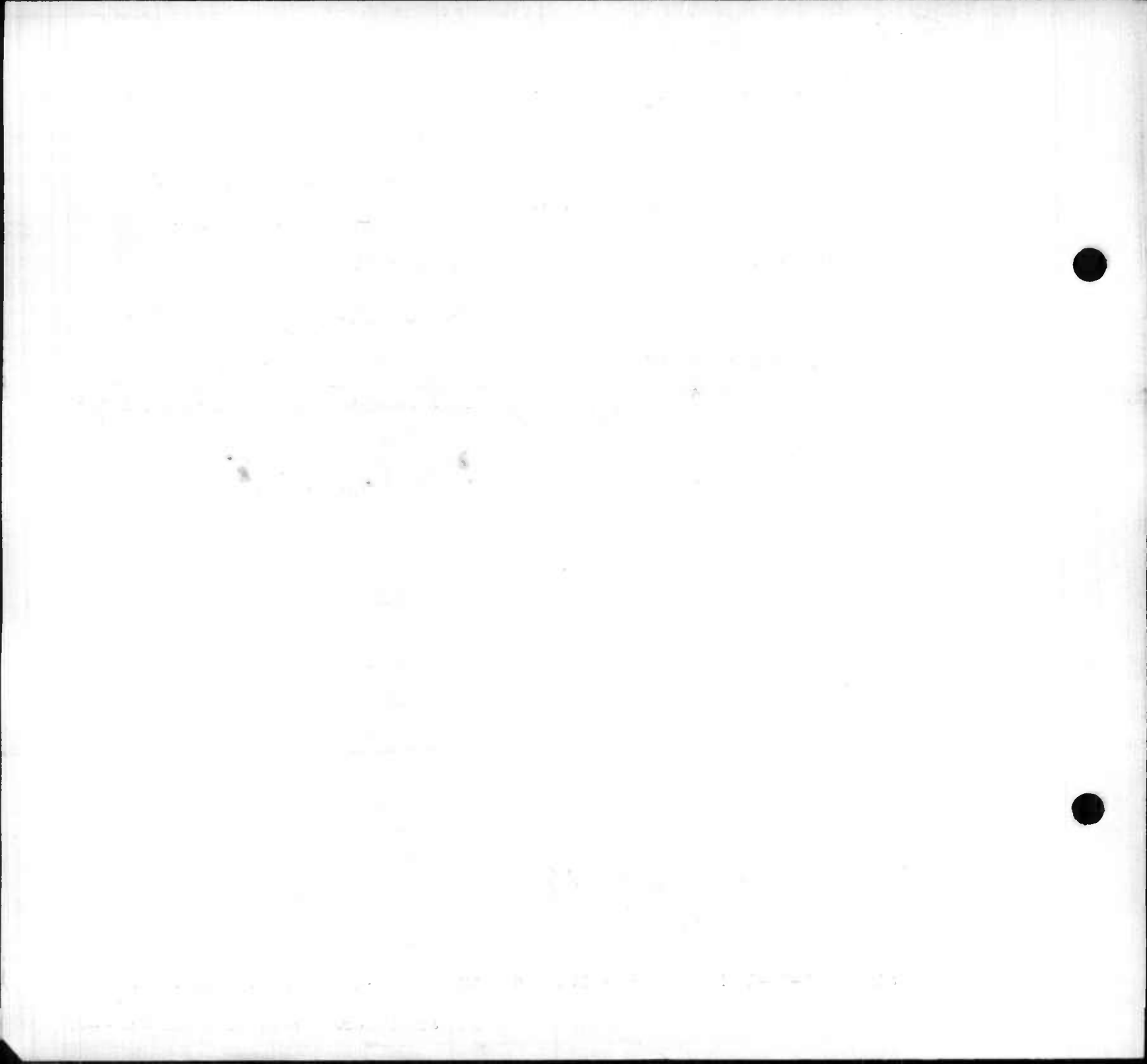
H-552		72 07973		BALTIMORE CITY HEALTH DEPARTMENT		72 07973	
BIRTH NO.		CERTIFICATE OF DEATH				STATE OF MARYLAND-DEPT.	
1. NAME OF DECEASED (Type or Print) CHARLES F. HEMMINGS				2. DATE AND HOUR OF DEATH Aug 18, 1972 4:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL 43				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND , Balto. 5300 C. CITY OR TOWN ARBUTUS D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4709 GATEWAY TERRACE 21227			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1887 FEB. 15, 1887		9. AGE (In years last birthday) 84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Hemmings				14. MOTHER'S MAIDEN NAME MARGARET MOORE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-07-5637-A		17. INFORMANT JOHN HEMMINGS - 188 W. Meadow Rd., Balt.			
18. 412.31 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF:							
(B) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF:							
(C) ARTERIOSCLEROTIC HEART DISEASE							
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Aug 17 19 72 to Aug 18 19 72 that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Virma V. Torres				23B. DATE SIGNED Aug 18, 1972			
23C. PHYSICIAN'S NAME (Type) VIRMA V. TORRES		23D. ADDRESS 5566 W. PATAPSCO AVE. APT 1-C, BALT., MD.					
24A. BURIAL CREMATION, REMOVAL (Specify) X BURIAL		24B. DATE 8-22-72		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Old Frederick Rd. Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR Anthony...		25C. FUNERAL DIRECTOR 3969		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

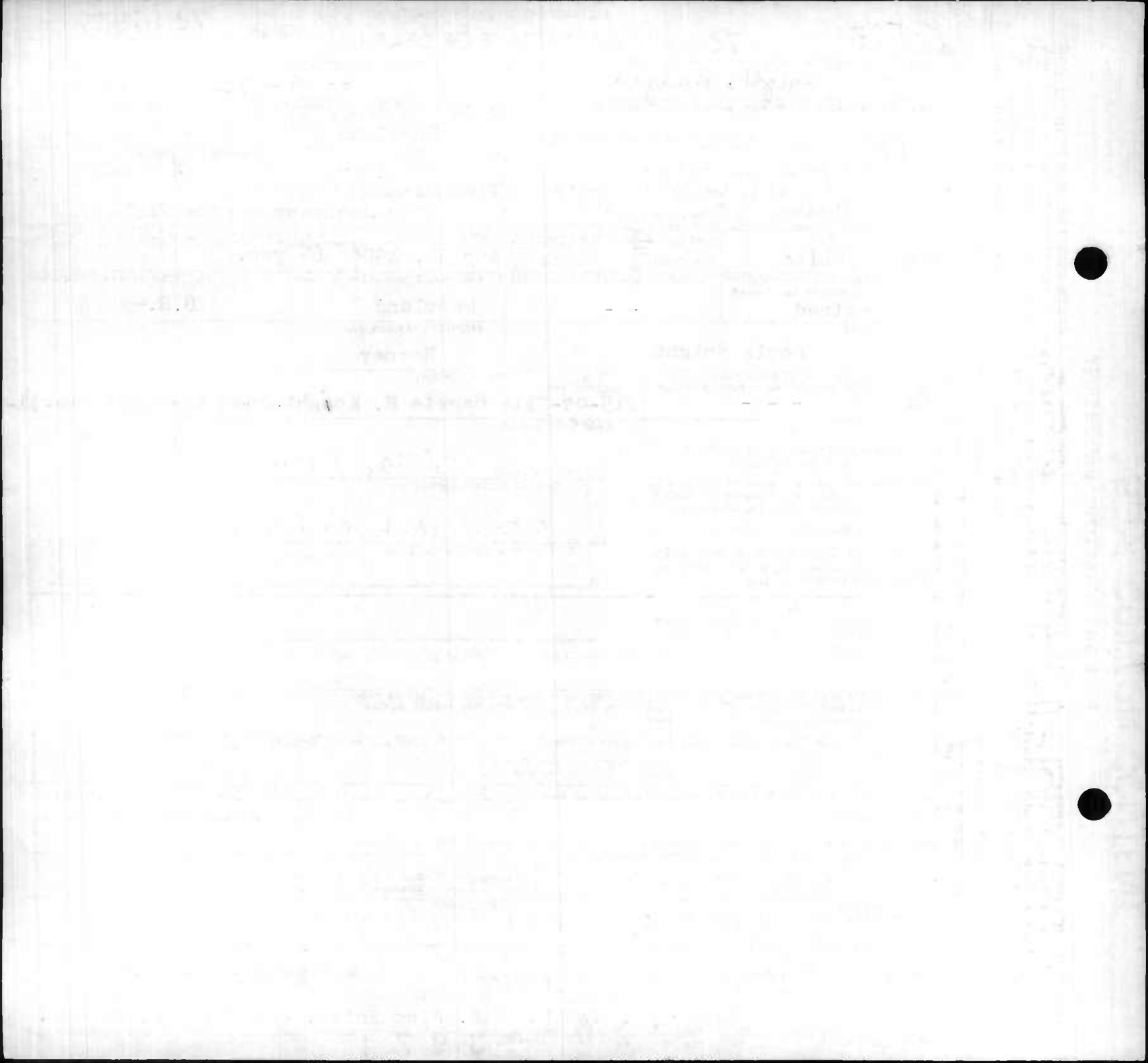
<div style="display: flex; justify-content: space-between;"> S-530 72 07974 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> 72 07974 CERTIFICATE OF DEATH </div>		REG. NO. 72 07974 STATE OF MARYLAND	
BIRTH NO. 5-530		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> 8-18-72 8 25 p.m. </div>	
1. NAME OF DECEASED (Type or Print) Schmidt, William G.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE md. B. COUNTY 1902	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) + Bon Secours Hospital		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1508 Hollins St.	
5. SEX male	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-11-82
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 89
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Schmidt		14. MOTHER'S MAIDEN NAME Pauline Doble mann	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-09-8344	17. INFORMANT ADDRESS Anna Schmidt 1508 Hollins St. 21223
18. 188X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: On a Road - E. driving (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Felimon A. Soria		23B. DATE SIGNED 8-18-72 Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23C. PHYSICIAN'S NAME (Type) FELIMON A. SORIA
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-21-1972	24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State) Wilkins Ave. Balto. Md.		25A. DATE RECEIVED BY HEALTH DEPT. AUG 22 1972	
25B. NAME OF REGISTRAR Ludwig...		25C. FUNERAL DIRECTOR ADDRESS Hubbard, Funeral Home, 4107 Wilkins Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 07975</u>	
K-523		72 07975		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Knight, Redgnel</u>		2. DATE AND HOUR OF DEATH <u>8-19-72</u> <u>12:30 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland Gen Hospital,</u> <u>827- Linden Avenue,</u> <u>Baltimore, Md 21201</u>		A. STATE <u>Maryland</u>		B. COUNTY <u>1338</u>	
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>2060 Rockrose Avenue 21211</u>					
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 31, 1906</u>	9. AGE (In years last birthday) <u>65 yrs.</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>- -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>					
13. FATHER'S NAME <u>Louis Knight</u>		14. MOTHER'S MAIDEN NAME <u>Rooney</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-09-7111</u>		17. INFORMANT <u>Carrie R. Knight-2060 Rockrose Ave-11-</u>	
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac Arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arterio-Sclerotic Cardiovascular Disease.</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-18-1972</u> to <u>8-19-1972</u> that (I) (we) lost saw the deceased alive on <u>8-19-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ahmed M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>M. Ahmed M.D.</u>		23D. ADDRESS <u>Maryland Gen. Hospital.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/23/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 22 1972</u>		25B. NAME OF REGISTRAR <u>Sidney H. Hinton</u>		25C. FUNERAL DIRECTOR <u>A. Alan Seitz, Jr. 3818 Roland Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. E-562		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 07976	
1. NAME OF DECEASED (Type or Print) EMRICH, GEORGE				2. DATE AND HOUR OF DEATH AUGUST 18, 1972 12:15 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 5513 ASHBOURNE RD 21227			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/91	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY MOBILE DINER		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOUIS EMRICH				14. MOTHER'S MAIDEN NAME CHRISTINE BRAUN EMRICH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 215-22-3576		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic obstructive Lung Disease				CAUSE OF DEATH (A) IMMEDIATE CAUSE Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF: (C) Chronic obstructive Lung Disease			
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from AUGUST 9 19 72 to AUGUST 18 19 72 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on AUGUST 18 19 72 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.							
23A. SIGNATURE Donato A. Vargas Jr				23B. DATE SIGNED 8-18-72		23C. PHYSICIAN'S NAME (Type) DONATO VARGAS, M.D.	
23D. ADDRESS BALTIMORE, MARYLAND 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVE S				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 8/21/72		24C. NAME OF CEMETERY or CREMATORY New Cathedral London Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR Didney Horton		25C. FUNERAL DIRECTOR ADDRESS Amprose INC 1328 Sulphur Sp. Rd			

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]
[Illegible]

ON: [Illegible]
[Illegible]

BY: [Illegible]
[Illegible]

DATE: [Illegible]
[Illegible]

TIME: [Illegible]
[Illegible]

PLACE: [Illegible]
[Illegible]

REASON: [Illegible]
[Illegible]

REFERENCE: [Illegible]
[Illegible]

NOTES: [Illegible]
[Illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-4604 4172 07977		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07977	
BIRTH NO.		CERTIFICATE OF DEATH		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) BLAIR, KEVIN		2. DATE AND HOUR OF DEATH 8/18/72		12 45 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore		5. CITY OR TOWN B. CITY OR TOWN	
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR APARTMENT) JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN B. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
33		E. STREET AND NUMBER 1054 ELM RD			
5. SEX MALE	6. RACE WHKTE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/03/69	9. AGE (In years last birthday) 2YRS 11MO	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME BLAIR, ROBERT		14. MOTHER'S MAIDEN NAME SHUTT SCOTT, MARGARET, KAREN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Robert C. Blair, 1054 Elm Rd	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory arrest (B) DUE TO, OR AS A CONSEQUENCE OF: Cor pulmonale (C) CYSTIC FIBROSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 7/12 to 8/18 19 72 that (we) last saw the deceased alive on 8/18 19 72 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE ASAENZ, MD		23B. DATE SIGNED 8/18/72			
23C. PHYSICIAN'S NAME (Type) ALBERTO SAEENZ, MD.		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/21/72		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR Sidney Whitson	
25C. FUNERAL DIRECTOR ADDRESS 1328 Sulphur Sp Rd					

8-28-1972 - Correction form, from Funeral Director, Ambrose, Inc., Balto., Md.

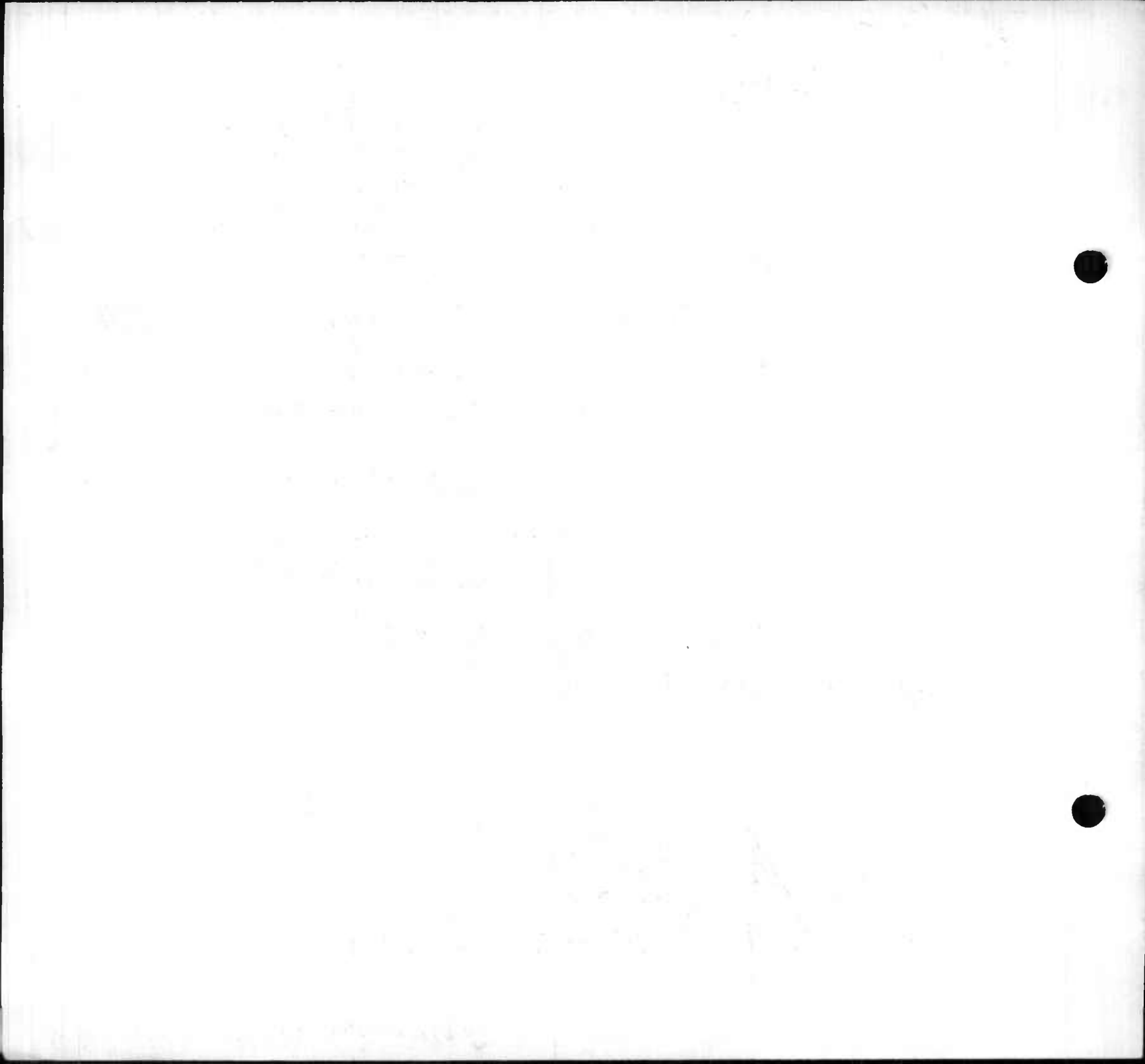
Birth Certificate of Kevin Michael Blair - 69-16837

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 07978 STATE OF MARYLAND-DEMD
V-525 BIRTH NO.		72 07978		
1. NAME OF DECEASED (Type or Print) <i>Van SANT, Caroline</i>		2. DATE AND HOUR OF DEATH <i>8/18/72 7:30 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University of Maryland Hosp 38</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <i>5531 Oregon Avenue Balt. 21227</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/16/95</i>	9. AGE (in years lost birthday) <i>77</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>John P. James</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>215-03 0855-B</i>		17. INFORMANT <i>Chart front sheet</i>
18. <i>562.11</i> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hrs</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF:
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>either Pulmonary emboli</i> DUE TO, OR AS A CONSEQUENCE OF: <i>or inferior wall MI</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>in hosp 10 day P.O. (D) Colectomy</i>				
19A. DATE OF OPERATION <i>18/9/72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Diver fibrosis</i>		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>8/12</i> 19 <i>72</i> to <i>8/18</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>8/18</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Michael F. Graham</i>				23B. DATE SIGNED <i>8/18/72</i>
23C. PHYSICIAN'S NAME (Type) <i>MICHAEL F. GRAHAM</i>		23D. ADDRESS <i>22 S. Green St Balt Md</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Partial</i>	24B. DATE <i>8/22/72</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Louisa Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 22 1972</i>		25B. NAME OF FUNERAL DIRECTOR <i>Anthony J. 2000</i>		25C. FUNERAL DIRECTOR ADDRESS <i>3 Cambridge Ave 128 Sulphur Sp, RI</i>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-650		72 07979		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07979	
BIRTH NO.				STATE OF MARYLAND - DHMH			
1. NAME OF DECEASED (Type or Print) MARTHA KERN				2. DATE AND HOUR OF DEATH 8/16/72 3p M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL				A. STATE MARYLAND B. COUNTY BALTIMORE			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 116 W. University Park							
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-25-88	9. AGE (In years last birthday) 83	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		
10B. KIND OF BUSINESS OR INDUSTRY —				11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN Lueckemeyer				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 212-05-2327D		17. INFORMANT Mr. Frederick Staud Mt. Vernon N.Y.	
18. 450X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SHOCK				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 DA 2 DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary Embolism, Myocardial Infarction				(B) DUE TO, OR AS A CONSEQUENCE OF:		13 DAYS	
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from 8/13/1972 to 8/16/1972 , that (I) (we) last saw the deceased alive on 8/16/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Peter H. Joyce M.D.				23B. DATE SIGNED 8/16/72		23C. PHYSICIAN'S NAME (Type) PETER H. JOYCE, M.D.	
23D. ADDRESS —		23E. NAME OF REGISTRAR Audrey H. Johnson		23F. FUNERAL DIRECTOR G. Truman Schwab		23G. ADDRESS 3512 Frederick Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 8/18/1972		24C. NAME OF CEMETERY OR CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR Audrey H. Johnson		25C. FUNERAL DIRECTOR G. Truman Schwab		25D. ADDRESS 3512 Frederick Ave.	

PETER H. JOYCE, M.D.

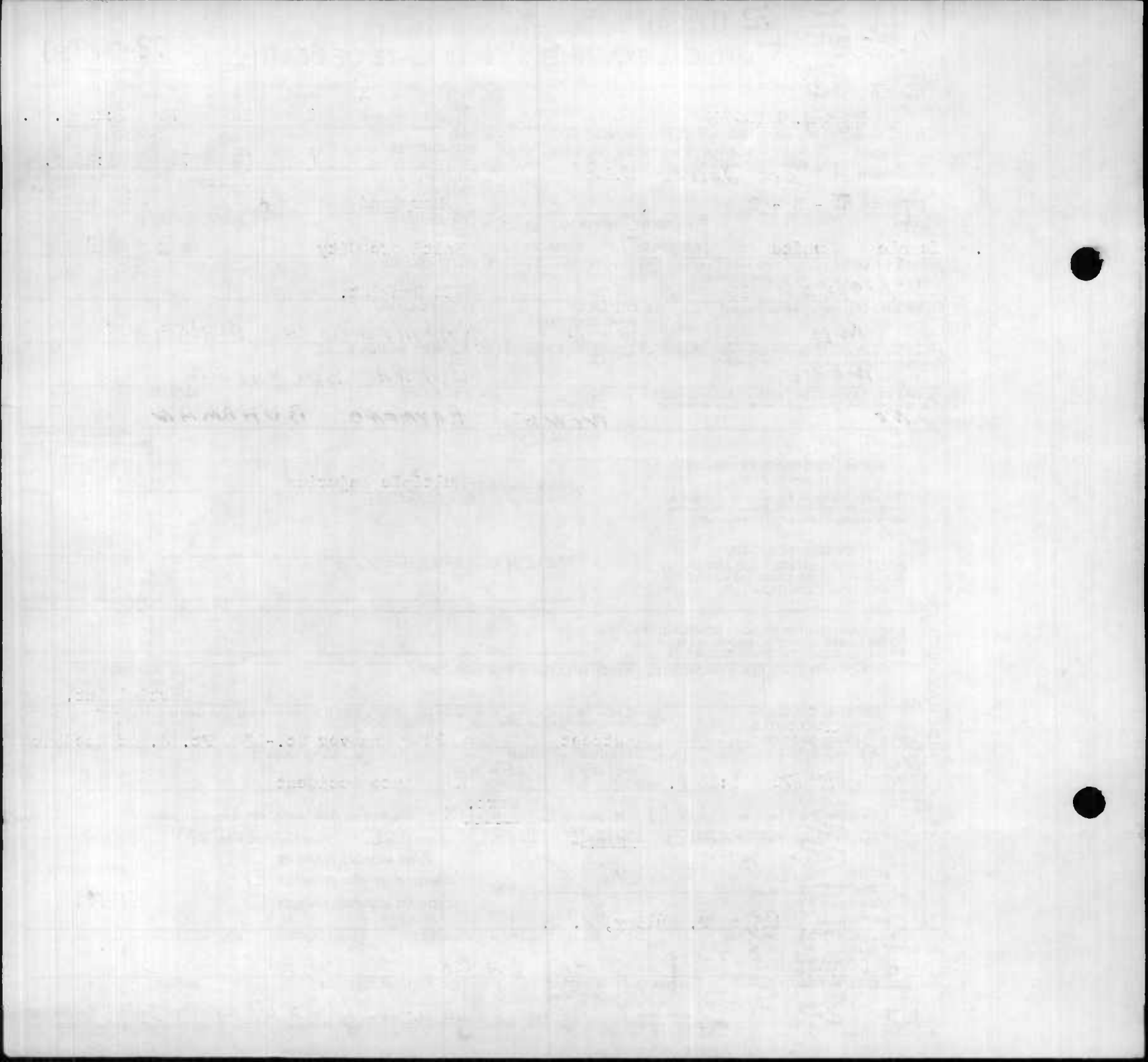
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 07980

BIRTH NO.

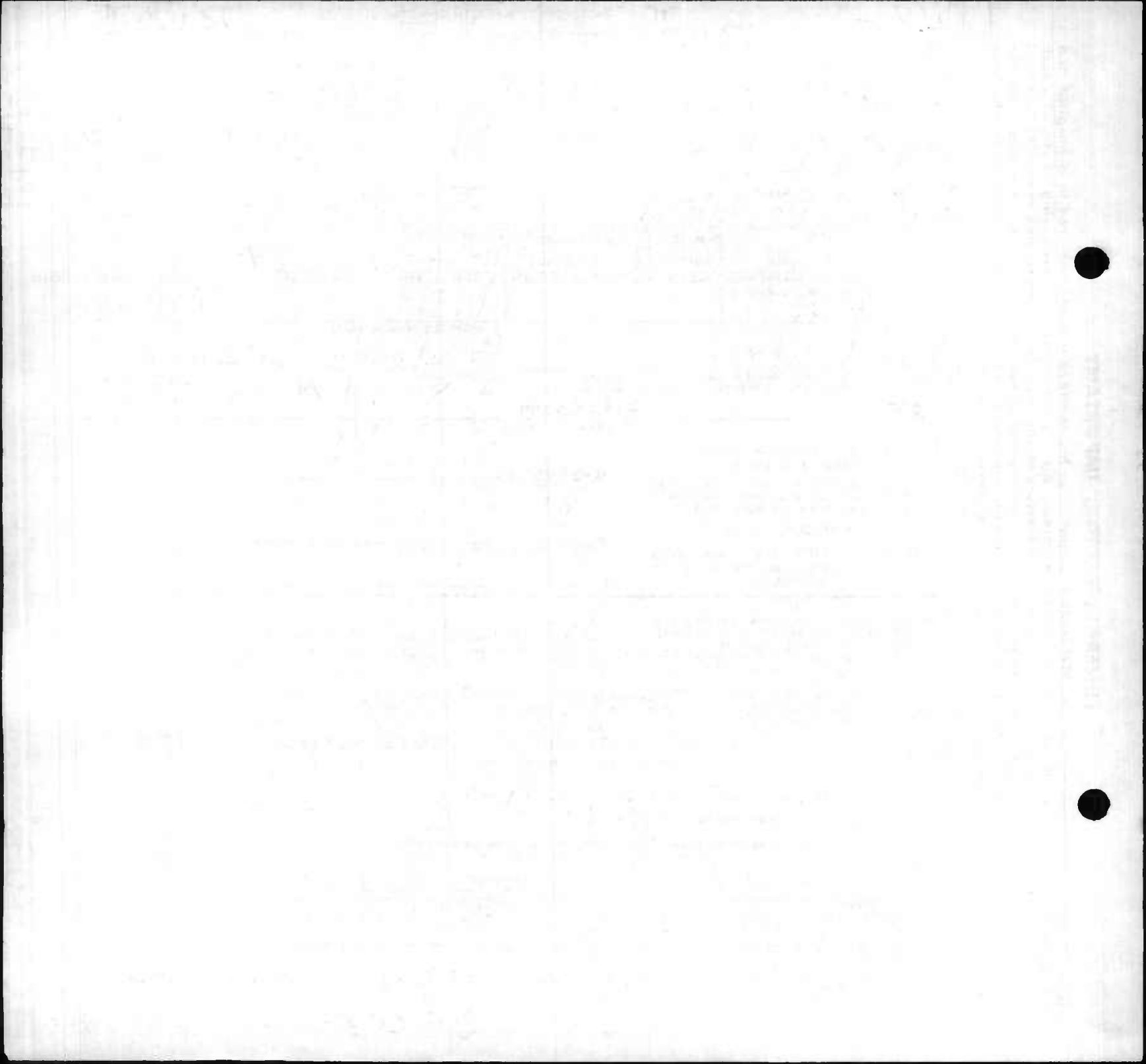
1. NAME OF DECEASED (Type or Print) ROSE D. BUHRMAN				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 18 72 1:25 P. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 S - B - 6				3. DATE PRONOUNCED DEAD Month Day Year Hour 8 18 72 1:25 P. M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO C. CITY OR TOWN Baltimore City D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
6. SEX female	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 8022 Bank St.			
9. DATE OF BIRTH 12/10/53		10. AGE (in years last birthday) 18		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NO JOB				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME BUENA BUCKALEW	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO				17. SOCIAL SECURITY NO. NONE		18. INFORMANT ADDRESS RAYMOND BUHRMAN	
19. E 819.81 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
						(A) IMMEDIATE CAUSE Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF:	
						(B) DUE TO, OR AS A CONSEQUENCE OF:	
						(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) Partial Aut.							
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 3200 Hanover St. - 1800 Ft. S. of Reedbird A			
22D. TIME OF INJURY (APPROX.) 8/18/72 1:10 P. M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Auto Accident			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> <u>Part. Autopsy</u> <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> <u>Accident</u> <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE W P Mulloy M.D. EXAMINER'S NAME (Type) William P. Mulloy, M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/19/72							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/22/72		24C. NAME OF CEMETERY or CREMATORY OAK LAWN		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR Audrey Brown		25C. FUNERAL DIRECTOR J. G. CONNELLY		ADDRESS 300 MACE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

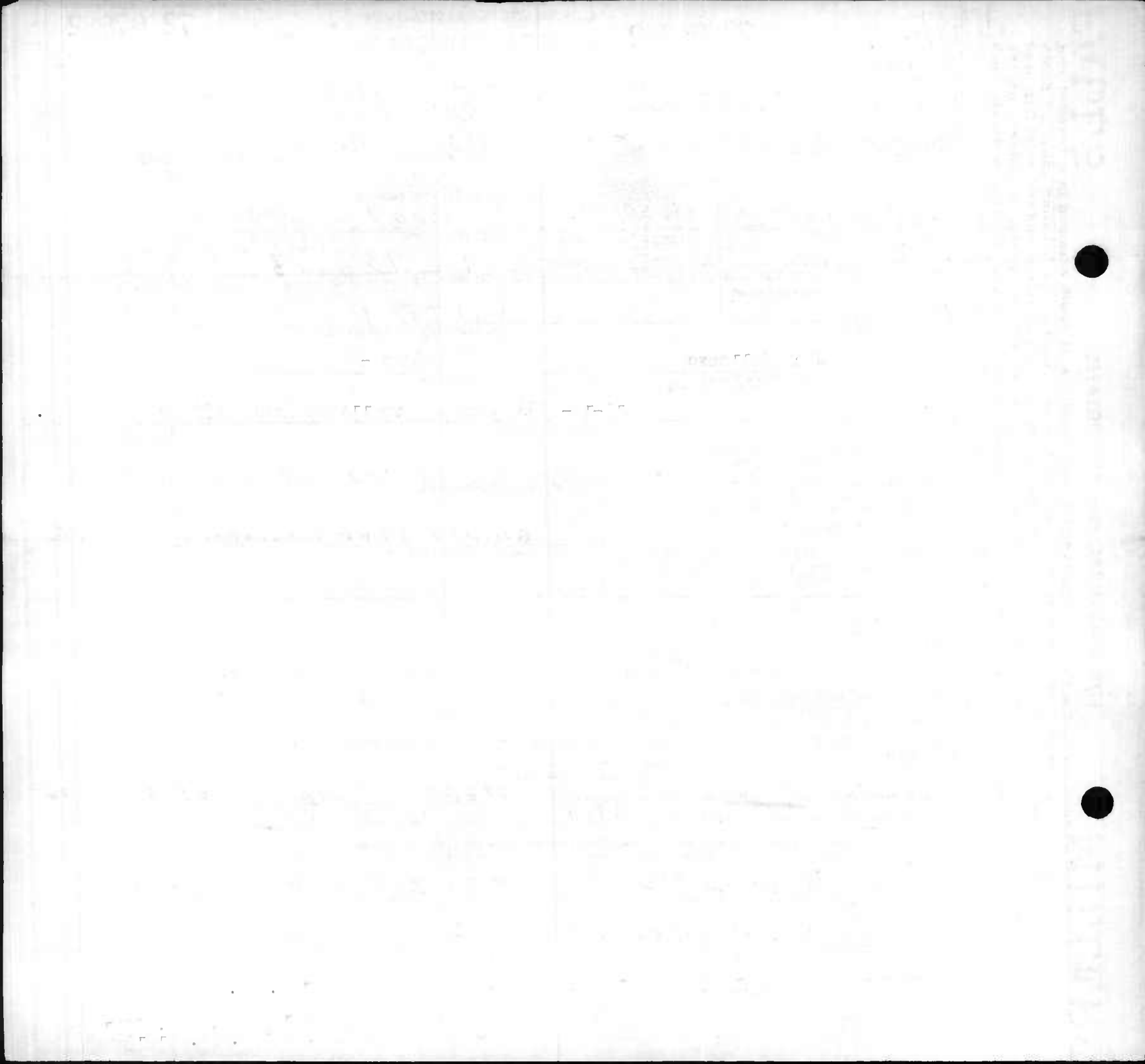
BALTIMORE CITY HEALTH DEPARTMENT				72 07981	
H-635				72 07981	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) ANNA E. HARTMAN				2. DATE AND HOUR OF DEATH 8-19-72 3:10 A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTO	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home Hospital 100 N Broadway St Baltimore MD 21231				C. CITY OR TOWN ESSEX D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 108 Margaret Av. E. 21221				9. AGE (In years lost birthday) 84	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-24-87		10. AGE (In years lost birthday) 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? American				13. FATHER'S NAME John Hoffman	
14. MOTHER'S MAIDEN NAME Gertrude Sitzman				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NP	
16. SOCIAL SECURITY NO. 218283366				17. INFORMANT A. Fouad Nour	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I Plute Myocardial Infarction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD Coronary artery disease CH-F	
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pulmonary Embolism				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Four days	
19A. DATE OF OPERATION 2 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY (Yes or No) Yes (Central)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) None	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? None			
22. I certify that (I) (this hospital) attended the deceased from 08-09 1972 to 8-19 1972 that (I) (we) last saw the deceased alive on 8-19 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Fouad Nour				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) A. Fouad Nour				23D. ADDRESS Church Home Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/22/72		24C. NAME of CEMETERY or CREMATORY SACRED HEART OF JESU	
24D. LOCATION (City, town, or county) (State) BALTO. MD.		25A. DATE REC'D BY HEALTH DEPT. 11-22-1972			
25B. NAME OF REGISTRAR L. J. Connelly		25C. FUNERAL DIRECTOR J. G. Connelly			
ADDRESS 300 MACE					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 07982		72 07982	
M-634				72 07982		72 07982	
72 07982				72 07982		72 07982	
72 07982				72 07982		72 07982	
1. NAME OF DECEASED (Type or Print) ANGELINA MARTELLOTTA				2. DATE AND HOUR OF DEATH 8/17 5:40 A			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO CITY			
FULL NAME OF HOSPITAL OR INSTITUTION 33				C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 3007 E. FEDERAL ST.				E. STREET AND NUMBER			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-2-93		9. AGE (In years, last birthday) 78	10. UNDER 1 Yr. 24 Hrs. 12 Hrs. 6 Hrs. 3 Hrs. 1 Hr. 30 Min. 15 Min. 10 Min. 5 Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jack Solizzo				14. MOTHER'S MAIDEN NAME Rose -			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 213-10-9966		17. INFORMANT Joseph Martellotta (son) ADDRESS 7433 Brookwood Ave.	
18. 576.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2				CAUSE OF DEATH (A) IMMEDIATE CAUSE GRAM NEG SEPSIS DUE TO, OR AS A CONSEQUENCE OF: (B) BILIARY TRACT OBSTRUCTION DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 hrs. 4 weeks	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/28 19 72 to 8/17 19 72 that (I) (we) last saw the deceased alive on 8/17 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE James H. Mersay MD				23B. DATE SIGNED 8/17		23C. ADDRESS JOHNS HOPKINS HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/27/72		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR Schimmek Funeral Homes, Inc.		25C. FUNERAL DIRECTOR 3331 Brehms		ADDRESS 3331 Brehms	



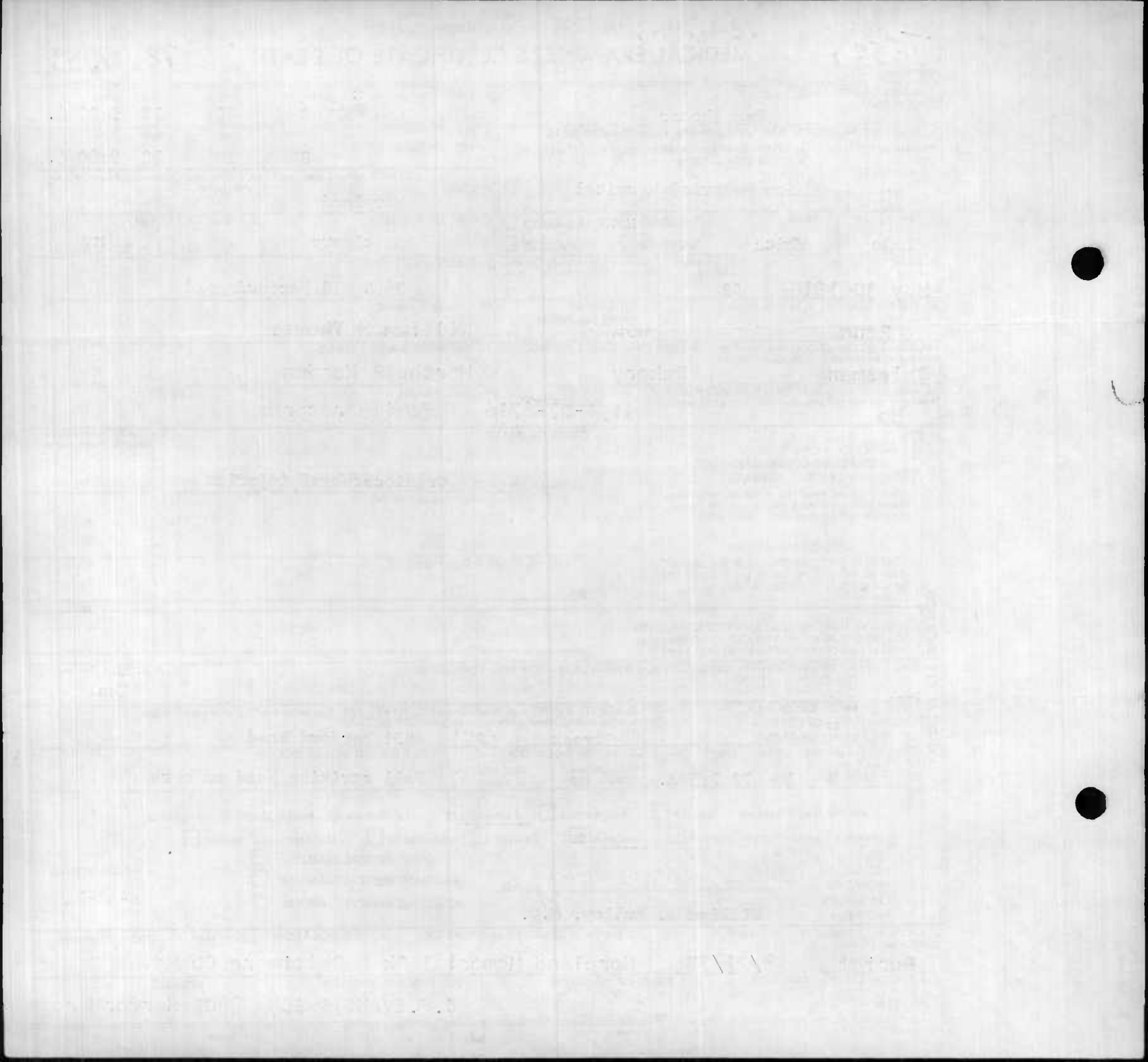
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07983

T-520

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ray Thomas				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 18 72 9:00 A. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 8 18 72 9:00 A. M.			
6. SEX Male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH May 30 1913				10. AGE (In years last birthday) 59		11. BIRTHPLACE (State or foreign country) Penn	
12. CITIZEN OF USA				13. FATHER'S NAME William H Thomas		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO	
15. MOTHER'S MAIDEN NAME Martha P Harden				16. CITY OR TOWN Baltimore		17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. STREET AND NUMBER 7603 Old Harford Road				19. DATE OF BIRTH May 30 1913			
20. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				21. KIND OF BUSINESS OR INDUSTRY Bakery			
22. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				23. SOCIAL SECURITY NO. 191-07-8716			
24. INFORMANT Family records				25. ADDRESS			
19. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E887X1							
(A) IMMEDIATE CAUSE Craniocerebral injuries DUE TO, OR AS A CONSEQUENCE OF:							
(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street 6831 Harford Road			
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 8 10 72 7:50A.m.				22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR? Fell striking head on curb				21. AUTOPSY? (Yes or No) Yes			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 8-18-72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/21/72		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Pk		24D. LOCATION (City, town, or county) (State) Baltimore Co Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR C.F. EVANS & SON		25D. ADDRESS 8802 Harford road	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				72 07984		REG. NO. 72 07984	
BIRTH NO. B-653				STATE OF MARYLAND - DEPT. OF HEALTH			
1. NAME OF DECEASED (Type or Print) EMMITT EUGENE BRYANT				2. DATE AND HOUR OF DEATH Aug. 20, 1972 6:35 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2302			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 2302 3100 Wyman Parkway				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1516 S. Charles St.							
5. SEX M	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/6/06	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH Bryant				14. MOTHER'S MAIDEN NAME ELLA MAE WOODS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 705-10-5894		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Pulmonary edema (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 24 hours							
ANTECEDENT CAUSES Cor pulmonae (B) DUE TO, OR AS A CONSEQUENCE OF: Years							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary emphysema (C) Years							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Aug. 10 19 72 to Aug. 20 19 72, that (I) (we) last saw the deceased alive on Aug/ 20 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John C. Sutherland, M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/21/72	
23C. PHYSICIAN'S NAME (Type) John Sutherland, MD				23D. ADDRESS US PHS Hospital, Balto, Md. 21211			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/23/72		24C. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM. PARK		24D. LOCATION (City, town, or county) (State) GLEN BURNIE, AA Co Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR Sidney W. Horton		25C. FUNERAL DIRECTOR		ADDRESS SINGLETON FUNERAL HOME GLEN BURNIE, MD.	

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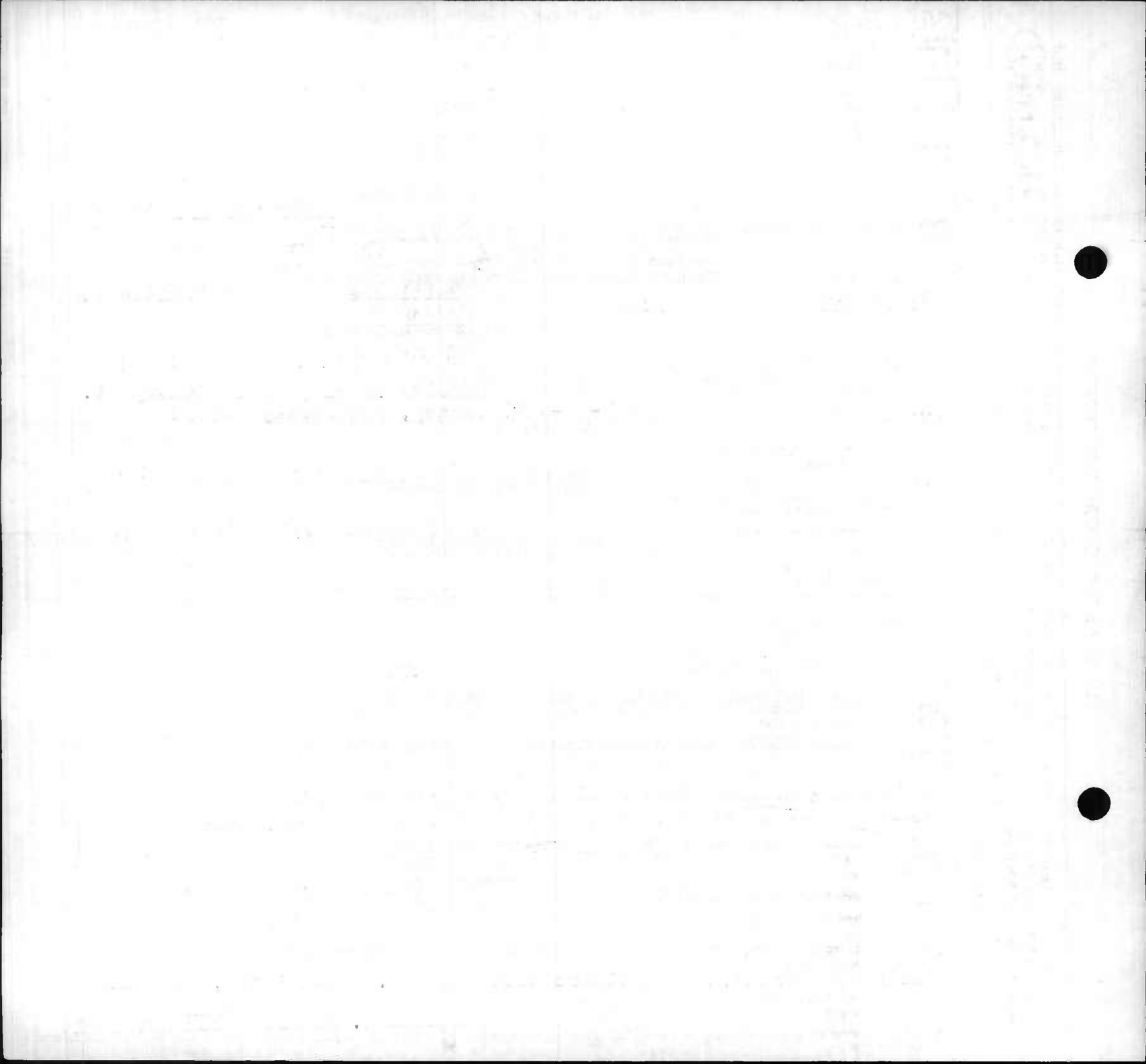
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 07985	
M-538 72 07985				CERTIFICATE OF DEATH	
BIRTH NO.		NAME OF DECEASED		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND-DEME	
MEINTZBERG CAROLYN B.		8/18/72 9:00 P.M.		STATE OF MARYLAND-DEME	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
UNION MEMORIAL HOSPITAL				MARYLAND BALTIMORE	
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
F W				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. DATE OF BIRTH 9. AGE (In years last birthday) 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				E. STREET AND NUMBER	
8-24-00 72 Housewife				Highland 21205	
11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME	
Baltimore UNICOWN				WILLIAM SNOWDR	
14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
KATHERINE MYERS				no	
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS	
218-18-0207				Carolyn Bradley 356 Hickory St. Garney, New Jersey 07032	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CARDIAC FAILURE MANY YEARS NO. IN DETECTED	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				HYPERTENSION / OLD H.I. UNKNOWN	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (Month 1 Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED	
21F. HOW DID INJURY OCCUR?				22. I certify that (this hospital) attended the deceased from 7-30-1972 to 8/18/1972 that (we) last saw the deceased alive on 8/18/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.	
23A. SIGNATURE				23B. DATE SIGNED	
P. H. B.				8/18/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE	
Burial				8/22/72	
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
Baltimore National Cem.				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR	
AUG 22 1972				William E. Johnson	
25C. FUNERAL DIRECTOR ADDRESS				25D. FUNERAL DIRECTOR ADDRESS	
8521				Loch Raven Blv	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-116		BALTIMORE CITY HEALTH DEPARTMENT		72 07986	
BIRTH NO.		72 07986		REG. NO. 72 07986	
1. NAME OF DECEASED (Type or Print)		DE BOUVER LEONIDE		2. DATE AND HOUR OF DEATH 9:35pm Aug 17-1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE	
CHURCH HOME AND HOSPITAL		1106 Gorsuch Ave.		MD.	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F		W.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Housewife.		at home		10-31-1891	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
JOHN BLANCHARD		MARIE ?		80	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		212-74-3073		Armand DeBouver (son) 1617 Dennis Ave.	
18. CAUSE OF DEATH		19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		Myocardial Infarction	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		22. I certify that (I) (this hospital) attended the deceased from 7/29/72 19 to 8/17/72 19	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
M. Yousuf Siddiqui MD.		August 17, 1972		M. Yousuf Siddiqui MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		8/21/72		Moreland Memorial Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 22 1972		Schimunek, Funeral Homes, Inc.		3331 Brehms Lane, Balto. Md. 21213	

9

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-430		72 07987		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07987	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) VICTORIA KALATA				2. DATE AND HOUR OF DEATH 8-17-72 1 330 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CO.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 10-20-48		9. AGE (in years last birthday) 23	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab. technician				10B. KIND OF BUSINESS OR INDUSTRY Hopkins Hospital		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME JOSEPH KALATA				14. MOTHER'S MAIDEN NAME ELIZABETH CARDINALE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service no				16. SOCIAL SECURITY NO.		17. INFORMANT Elizabeth West (mother)	
18. 201X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). RECENT SURGERY FOR PERFORATED PEPTIC ULCER				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 1-16-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED DISSISSENCE ABDOMINAL WOUND		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-17-72 1:30 PM to 8-17-72 3:30 PM that (I) (we) last saw the deceased alive on 8-17-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE C. Kent Osborne M.D.				23B. DATE SIGNED 8-17-72			
23C. PHYSICIAN'S NAME (Type) C. KENT OSBORNE, M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/21/72		24C. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR Andrew Johnston		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.		ADDRESS 3331 Brehms Lane, Balto. Md. 21213	

030

WILLIAM L. BROWN, JR.
JULY 1, 1911
BIRMINGHAM, ALA.
ELIZABETH C. BROWN

JULY 1, 1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
72 07988 CERTIFICATE OF DEATH										
REG. NO. 72 07988										
1. NAME OF DECEASED (Type or Print) <u>VINCENT T. KRANKOWSKI</u>					2. DATE AND HOUR OF DEATH <u>AUGUST 17, 1972 11:05 P.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, or institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2610</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 The Johns Hopkins Hospital</u>					C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					E. STREET AND NUMBER <u>600 N. East Avenue</u>					
5. SEX <u>Male</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/1/11</u>	9. AGE (In years last birthday) <u>61</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chef</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Brentwood Inn</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Walter Krankowski</u>					14. MOTHER'S MAIDEN NAME <u>Anna Tomczyk</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>056-18-9041</u>		17. INFORMANT <u>Margaret Krankowski (wife)</u>			ADDRESS <u>same as above</u>		
18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE <u>ACUTE PULMONARY EDEMA</u> 20 MINUTES DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CONGESTIVE HEART FAILURE</u> 1 1/2 yrs. DUE TO, OR AS A CONSEQUENCE OF: (C) <u>MASSIVE MYOCARDIAL INFARCT</u> 20 yrs.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>POSSIBLE PERICARDITIS</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 1st</u> 19 <u>72</u> to <u>AUGUST 17</u> 19 <u>72</u> that (I) was last saw the deceased alive on <u>AUGUST 17</u> 19 <u>72</u> and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.										
23A. SIGNATURE <u>Edm B. Welch M.D., Ph.D.</u>					23B. DATE SIGNED <u>8/17/72</u>			23C. PHYSICIAN'S NAME (Type) <u>JOHN B. WELCH M.D., Ph.D.</u>		
23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL, BALT. MD.</u>										
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/21/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 22 1972</u>			25B. NAME OF REGISTRAR <u>Aiding in death</u>			25C. FUNERAL DIRECTOR <u>Schmiegke Funeral Homes, Inc.</u>			ADDRESS <u>3331 Brehms Lane, Balto. Md. 21213</u>	

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D-120

72 07989

STATE OF MARYLAND - DHMH
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07989

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CLEVEN DAVIS				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 8 18 72 10:00 P.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland Gen. Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 8 18 72 10:00 PM.			
14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 909				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 909			
6. SEX Male	7. RACE negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore City		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 5/27/42		10. AGE (In years lost birthday) 30		E. STREET AND NUMBER 1417 Ensor St.			
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Summie Davis			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Construction		15. MOTHER'S MAIDEN NAME Mandy Williams			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS OTTO DAVIS 1417 N. ENSOR ST			
19. CAUSE OF DEATH E965X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) BAR		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? L & G Bar 1205			
22D. TIME OF INJURY (APPROX.) 8 18 72 9:00 m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/19/72							
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 8/22/72		24C. NAME OF CEMETERY or CREMATORY Pleasant Hill		24D. LOCATION (City, town, or county) (State) Enfield N.C.	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR Joseph B. Lock Jr.		ADDRESS 1304 N. Central St.	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07990

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT EUGENE PERLIE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 19 72 6:23 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1420 N. Bond St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 19 72 6:23 A. M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore City	
9. DATE OF BIRTH MAY 16, 1934		10. AGE (In years last birthday) 38	
11. BIRTH PLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Minnie Bridges		18. INFORMANT ADDRESS Minnie Perlle 1420 N. Bond St.	
19. 412.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) No	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE W P Mulloy M.D. EXAMINER'S NAME (Type) William P. Mulloy, M.D. DATE SIGNED 8/20/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-24-72	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem Park		24D. LOCATION (City, town, or county) (State) Arbutus Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR Edith M. M. M.	
25C. FUNERAL DIRECTOR Elliott Funeral Home		ADDRESS 1129 N. Caroline St.	

ST. JOHN'S COLLEGE, NEW BRUNSWICK, CANADA

THE PRESIDENT, ST. JOHN'S COLLEGE, NEW BRUNSWICK, CANADA

DEAR SIR,

I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the above.

I am sorry to hear that you are unable to attend the meeting.

I am, Sir, very respectfully,
Yours truly,
J. P. [Signature]

ST. JOHN'S COLLEGE, NEW BRUNSWICK, CANADA

THE PRESIDENT, ST. JOHN'S COLLEGE, NEW BRUNSWICK, CANADA

DEAR SIR,

I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the above.

I am sorry to hear that you are unable to attend the meeting.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Kevin T. Simms		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour		Month Day Year Hour		A. STATE B. COUNTY	
8 21 72 4:30a. M.		8 21 72 4:30a. M.		Maryland		1702			
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. DATE OF BIRTH		10. AGE (In years last birthday)	
male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4/12/68		4	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
Baltimore, Md.		USA		Reginald Simms		n/a		Diane Davis	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		19. CAUSE OF DEATH		20. DATE OF OPERATION	
n/a		n/a		Diane Davis		Blunt injury to abdomen with laceration of liver		2	
21. AUTOPSY? (Yes or No)		22. WHERE DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. BURIAL CREMATION, REMOVAL (Specify)		25. DATE REC'D BY HEALTH DEPT.	
yes		intersect. Blunt St. & 500Blk. Lafayette		pedestrian struck by auto		BURIAL		AUG 22 1972	
26. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		27. DATE SIGNED		28. NAME OF REGISTRAR		29. FUNERAL DIRECTOR		30. ADDRESS	
Russell S. Fisher, M.D.		8-21-72		Sidney Whorton		MORTON & DYETT FUNERAL HOME, 1701 Laurens		Baltimore, Md. 21217	

1957

100-55



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 07992

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) TONY GILMER				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 19 72 2:47 A. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 8 19 72 2:47 A. M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1802				C. CITY OR TOWN Baltimore City D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX Male		7. RACE negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 1211 W. Lexington St.	
9. DATE OF BIRTH 8-7-71		10. AGE (In years lost birthday) 1		11. BIRTHPLACE (State or foreign country) BALTO, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY INFANT		13. FATHER'S NAME TYRONE GILMER	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME CATHERINE BOWERS	
18. INFORMANT MRS. VIOLA BOWERS				ADDRESS 1715 W. MOSHER ST.			
19. E-864X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH Ingestion of petroleum hydrocarbons (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1211 W. Lexington Street 18-02			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR? Ingested petroleum hydrocarbons			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE W.P. Mulloy M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) William P. Mulloy, M. D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8/19/72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-22-72		24C. NAME of CEMETERY or CREMATORY MT. AUBURN CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR William P. Mulloy		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F. H. 1701 LAURENS ST.			

11/17/72 - Letter from M.E.O., Dr. Wm. Mulloy.

ABC

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-450		72 07993		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 07993	
BIRTH NO.				STATE OF MARYLAND - DUNN			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
LORETTA ALLEN				8-17-72			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
00 3706 FLOWERTON ROAD				MARYLAND		1608	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				3706 FLOWERTON ROAD			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days	
F	B	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10-28-34	37		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		SOCIAL SECURITY		BALTIMORE, MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ROBERT HILL				MARY ELIZABETH HILL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO				MR. EARL ALLEN		3706 FLOWERTON ROAD	
18. <u>180X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				Cancer - Cervix - ovaries			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
				Metastasis			
				Colorectal		5 mo.	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <u>8/9/72</u> 19 to <u>8/17/72</u> 19, that (I) (we) last saw the deceased alive on <u>8/16</u> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Joseph S. Blum				8/18/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JOSEPH S. BLUM MD				115th Calvert St			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		8-20-72		MT AUBURN CEMETERY		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 22 1972		Frederick B. Johnson		MORTON & DYETT FUNERAL HOMES		1701 LAURENS S	

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W-000

72 07994 STATE OF MARYLAND-DEMH
BALTIMORE CITY HEALTH DEPARTMENT

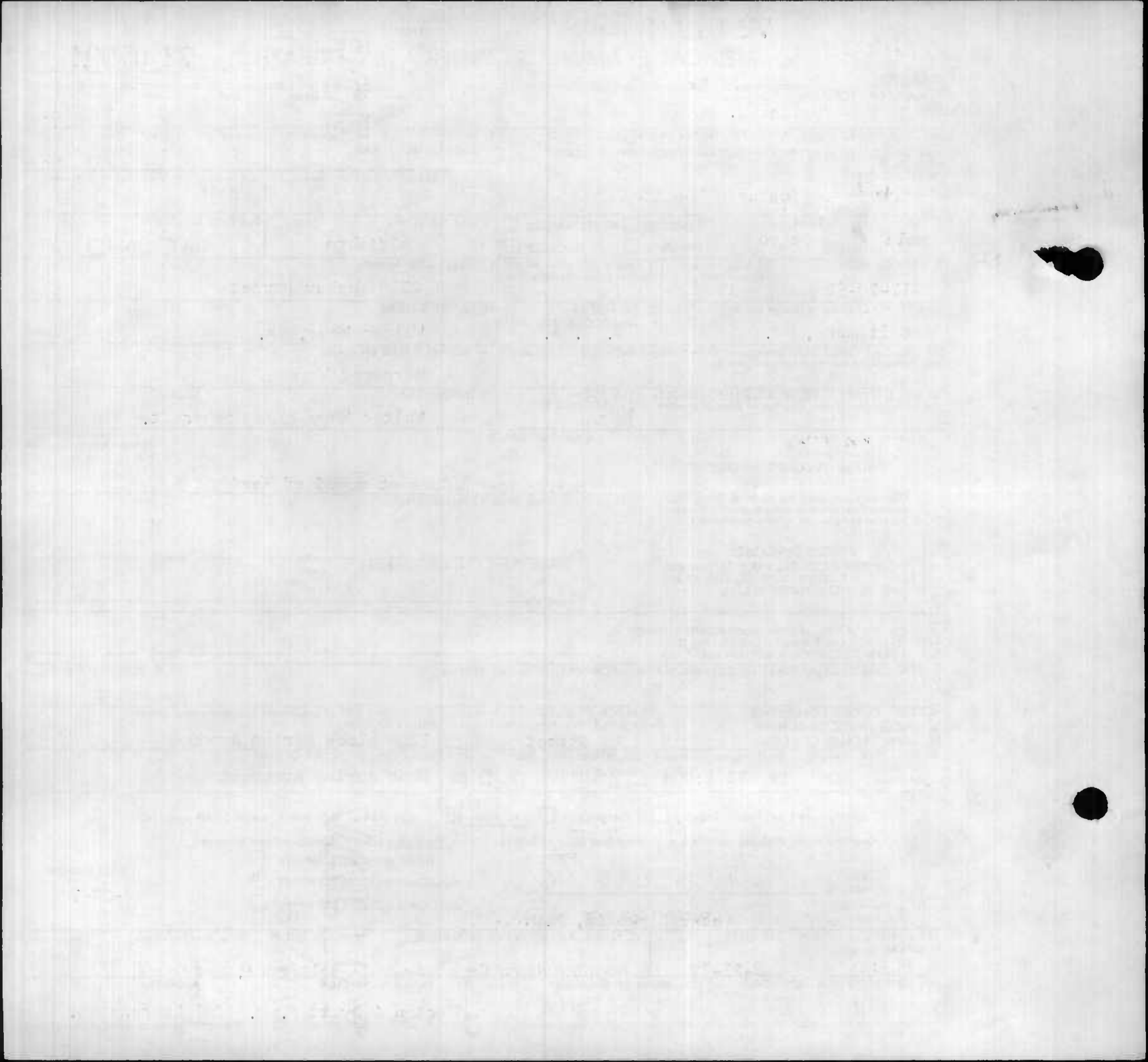
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07994

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Walter E. Whye				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 8 Day 19 Year 72 Hour 8:05 A. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital				3. DATE PRONOUNCED DEAD Month 8 Day 19 Year 72 Hour 8:05 A. M.			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1606							
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 12-20-52		10. AGE (In years last birthday) 19		E. STREET AND NUMBER 2708 Mosher Street			
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF U. S. A.		13. FATHER'S NAME Walter Whye, Sr.			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Margaret Whye			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Walter Whye 2708 Mosher St.			
19. E 965X1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				(A) IMMEDIATE CAUSE Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF:			
				(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1200 block Harlem Avenue	
22D. TIME OF INJURY (APPROX.) 8 19 72 1:00A		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during argument			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovid M.D. EXAMINER'S NAME (Type) Peter Lipkovid, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-20-72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-23-72		24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR Andrew H. Hinton		25C. FUNERAL DIRECTOR ADDRESS Morton & Dyett F. H. 1701 Laurens St.			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07995

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles E. Harris		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 8 21 72 4:20 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If not in hospital or institution, give street address or location) 48 Maryland General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 21 72 4:20 a. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 1608			
6. SEX male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 9-5-53		10. AGE (In years last birthday) 18	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Harris		14. MOTHER'S MAIDEN NAME Francis Harris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-56-9105	
17. INFORMANT Mrs. Francis Harris		18. ADDRESS 3503 Gelston Drive	
19. CAUSE OF DEATH E9651X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Gunshot Wound of Head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) 21 yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1000 blk. Argyle Avenue		22D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) OF INJURY (APPROX.) 8 13 72 11 p. m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? shot by unknown assailant	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE R. Fisher M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Russell S. Fisher, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-21-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-24-72	24C. NAME of CEMETERY or CREMATORY Carver Memorial Pk.	24D. LOCATION (City, town, or county) (State) Laurel, Maryland
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR Arthur H. H. H.	
25C. FUNERAL DIRECTOR Morton & Dyett F. H.		25D. ADDRESS 1701 Laurens St.	

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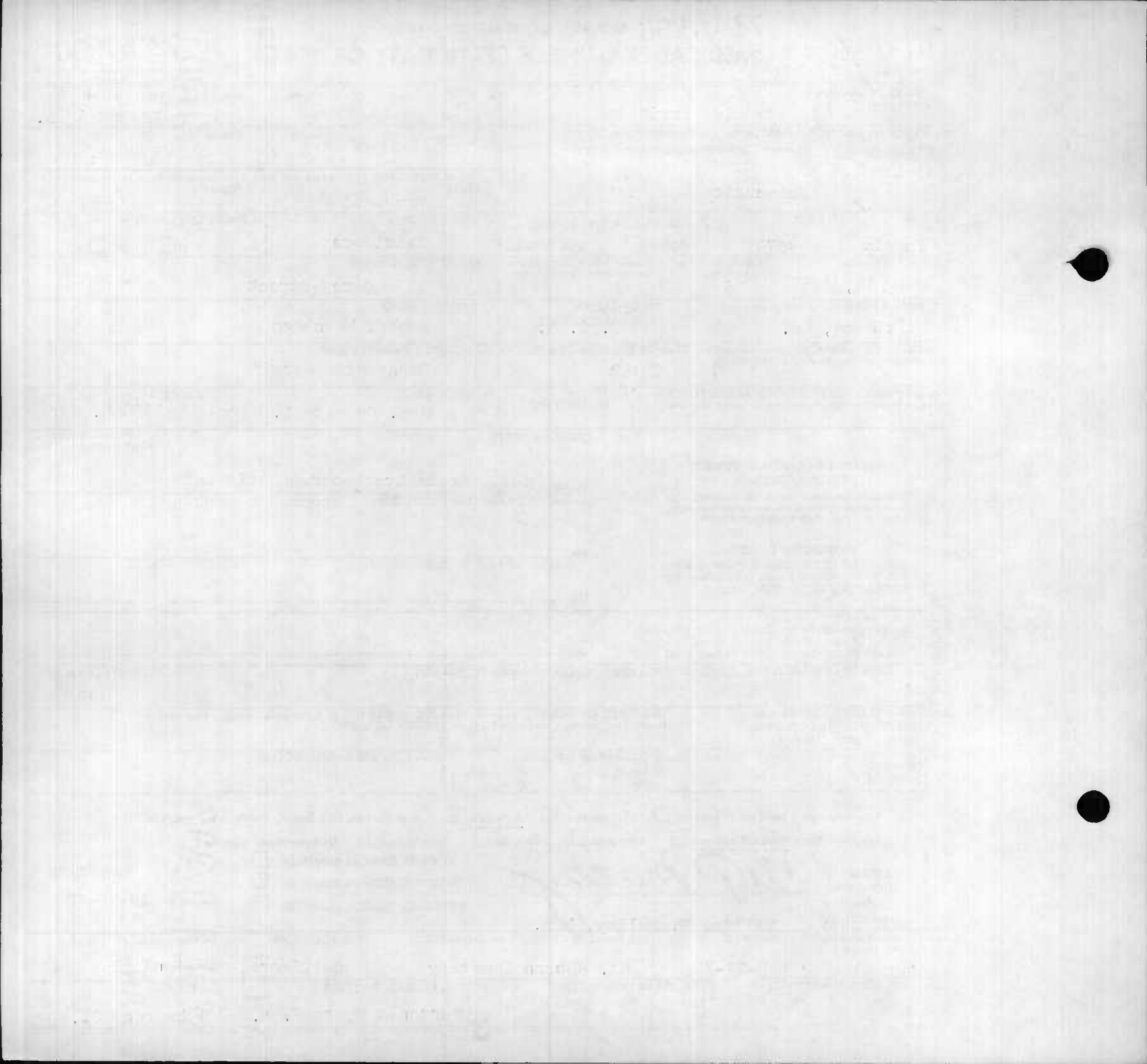
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STATE OF MARYLAND - DEATH									
72 07936 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
BIRTH NO. 67-09175 REG. NO. 72 07936									
1. NAME OF DECEASED (Type or Print) Constancia Morris					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 8 Day 19 Year 72 Hour 8:40 A.M.				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital					3. DATE PRONOUNCED DEAD Month 8 Day 19 Year 72 Hour 8:40 A.M.				
					5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1601				
6. SEX Female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH May 14, 1967		10. AGE (In years last birthday) 5		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		E. STREET AND NUMBER 1156 Carey Street	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY CHILD		13. FATHER'S NAME Robert Weinberg		15. MOTHER'S MAIDEN NAME Bernadette Morris			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Celeste L. Morris		ADDRESS 1156 N. Carey			
19. 466X1 CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE Acute tracheobronchitis and DUE TO, OR AS A CONSEQUENCE OF: bronchopneumonia				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					(B) DUE TO, OR AS A CONSEQUENCE OF:				
					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED						21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>W.P. Mulloy</i> M.D. EXAMINER'S NAME (Type) William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-20-72									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-22-72		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR <i>A. J. Dyett</i>		25C. FUNERAL DIRECTOR ADDRESS Morton & Dyett F. H. 1701 Laurens St.					

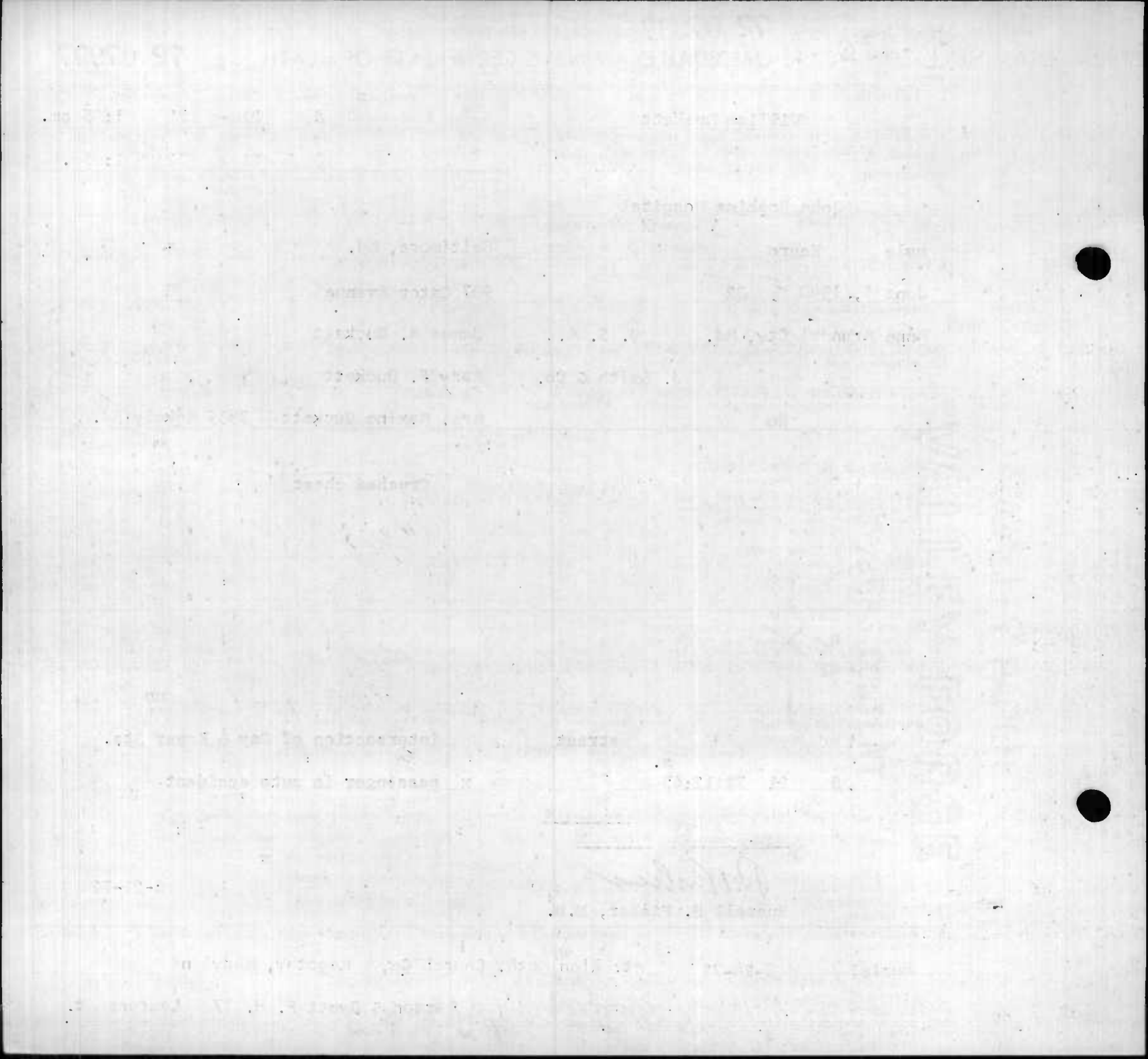


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 07997

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Duckett		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 8 21 72 1:05 am	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 John Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 21 72 1:05a. M.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 901	
9. DATE OF BIRTH June 1, 1940		10. AGE (In years last birthday) 32	
11. BIRTHPLACE (State or foreign country) Anne Arundel Cty, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James A. Duckett		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) J. Smith & Co.	
15. MOTHER'S MAIDEN NAME Mary F. Duckett		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Maxine Duckett	
19. CAUSE OF DEATH E 819.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Crushed chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office Bldg., etc.) street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) intersection of Gay & Eager Sts. 704	
22D. TIME OF INJURY (APPROX.) 8 21 72 12:45		22E. INJURY OCCURRED a. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? passenger in auto accident		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-21-72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-24-72	
24C. NAME OF CEMETERY or CREMATORY Mt. Zion Meth. Church Ce,		24D. LOCATION (City, town, or county) (State) Magothy, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR Aidney	
25C. FUNERAL DIRECTOR Morton & Dyett F. H.		25D. ADDRESS 1701 Laurens St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



THE UNIVERSITY OF CHICAGO



Received from Mr. Arthur (unclear) 1900
the sum of \$100.00

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-200

72 07999

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 07999

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Rich Edward

2. DATE AND HOUR OF DEATH

8-19-72

1:00 P.

STATE OF MARYLAND-DEMH

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

39 Provident Hospital Inc.

Male

B

5. SEX

male

6. RACE

B

7. MARRIED

NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

1601

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1112M Mosher st

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF WHAT COUNTRY?

U.S

13. FATHER'S NAME

Hosie Penn

14. MOTHER'S MAIDEN NAME

Edna Rich

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

224-38-4947

17. INFORMANT

ADDRESS

Lula Rich 116 N. Carrollton Ave.

18. 436.01

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiorespiratory Arrest

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Cerebrovascular Accident

(C)

Severe Hypertension

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John G. Tool

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-24-72

24C. NAME of CEMETERY or CREMATORY

Church Cemetery

24D. LOCATION

Lancaster Co. Va.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 22 1972

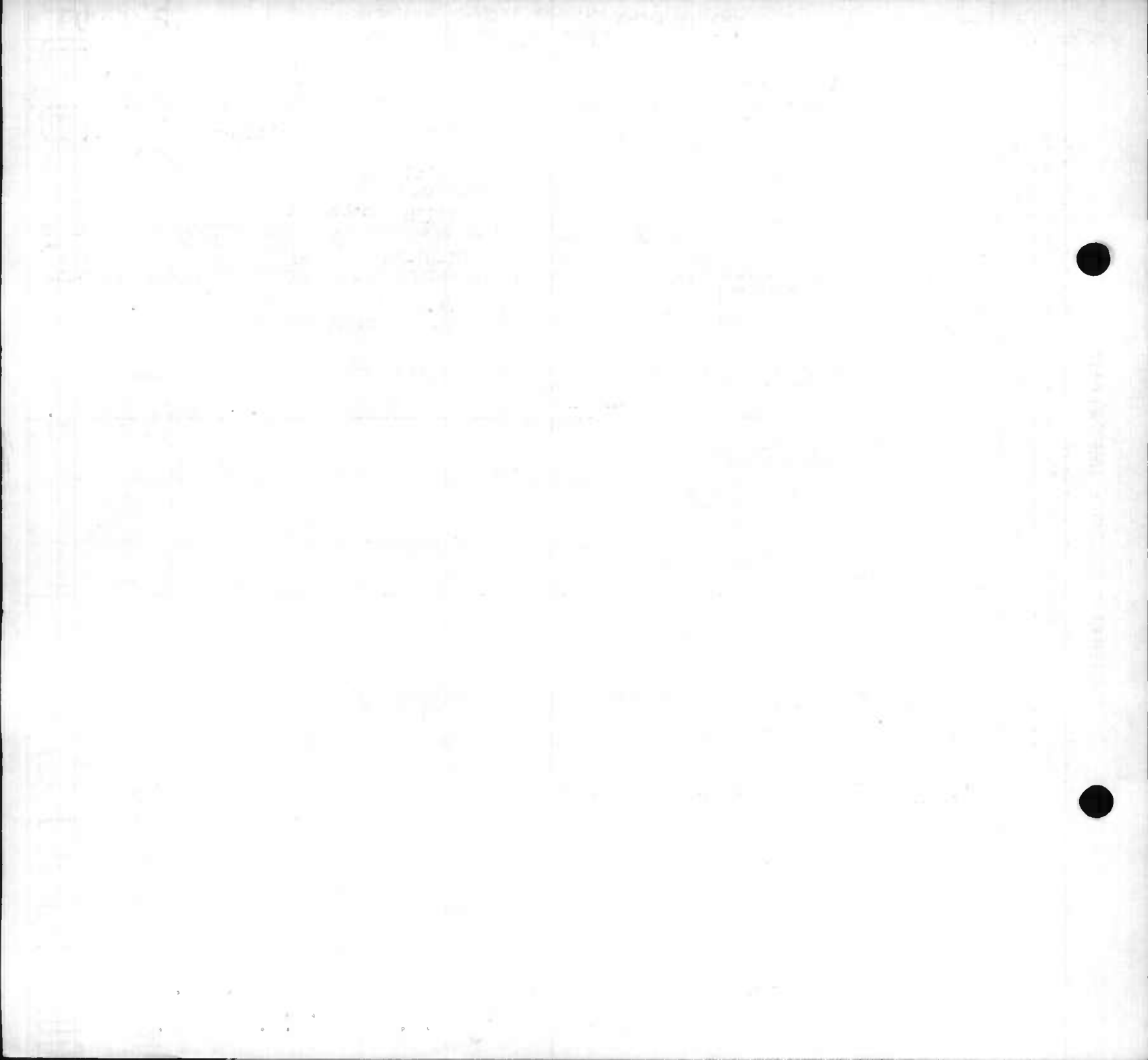
25B. NAME OF REGISTRAR

Frederick H. H. H.

25C. FUNERAL DIRECTOR

Geo. G. Kellison F.H. 1348 N. Calhoun

ADDRESS



1
B-620

72 08000

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08000

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SPENCER GROSS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 18 72 4:12 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 18 72 4:12 P.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1502	
6. SEX Male	7. RACE negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore City	
9. DATE OF BIRTH Dec. 19, 1946		10. AGE (in years last birthday) 25	11. Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 1542 N. Bruce St.
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Richard Gross	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT Celestine James 1913 Gwynnfall P.M.	
19. 5-71-81		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Fatty Metamorphosis of Liver DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) _____			
20A. DATE OF OPERATION 2/1		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE W P Mulloy M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) William P. Mulloy, M. D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8/19/72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/23/72		24C. NAME OF CEMETERY or CREMATORY W. H. H. Cemetery	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972			
25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR Williams Funeral Home 3419 Schenck St.		ADDRESS	

